2024 COMMUNITY HEALTH NEEDS ASSESSMENT

Columbus Regional Health Service Area

Sponsored by

COLUMBUS REGIONAL HEALTH

2023-0440-02

Prepared by
www.PRCExcellence.com

TABLE OF CONTENTS

INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment — a follow-up to similar studies conducted in 1996, 2000, 2003, 2006, 2009, 2012, 2015, 2018, and 2021 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Columbus Regional Health. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Columbus Regional Health by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

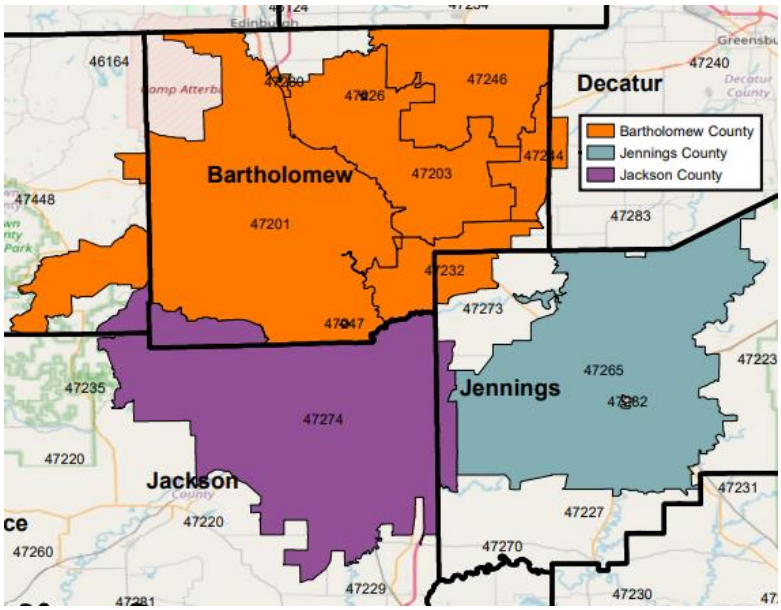
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Columbus Regional Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Columbus Regional Health Service Area” or “CRH Service Area” in this report) is defined as each of the residential ZIP Codes primarily associated with Bartholomew County, as well as ZIP Codes 47265 in Jennings County and 47274 in Jackson County, in Indiana. This community definition, determined based on the ZIP Codes of residence of recent patients of Columbus Regional Health, is illustrated in the following map.



Sample Approach & Design

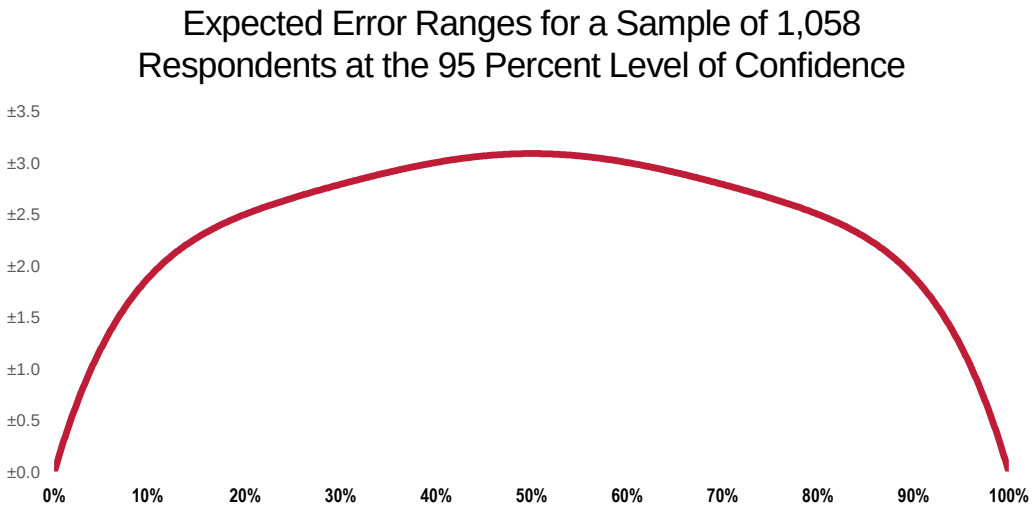
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (landline and cell phone) or through online questionnaires, as well as a community outreach component promoted by the study sponsors through social media posting and other communications.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 500 surveys throughout the service area.

COMMUNITY OUTREACH SURVEYS (Columbus Regional Health) ► PRC also created a link to an online version of the survey, and Columbus Regional Health promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 558 surveys to the overall sample.

In all, 1,058 surveys were completed through these mechanisms. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Columbus Regional Health Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 1,058 respondents is ±3.1% at the 95 percent confidence level.



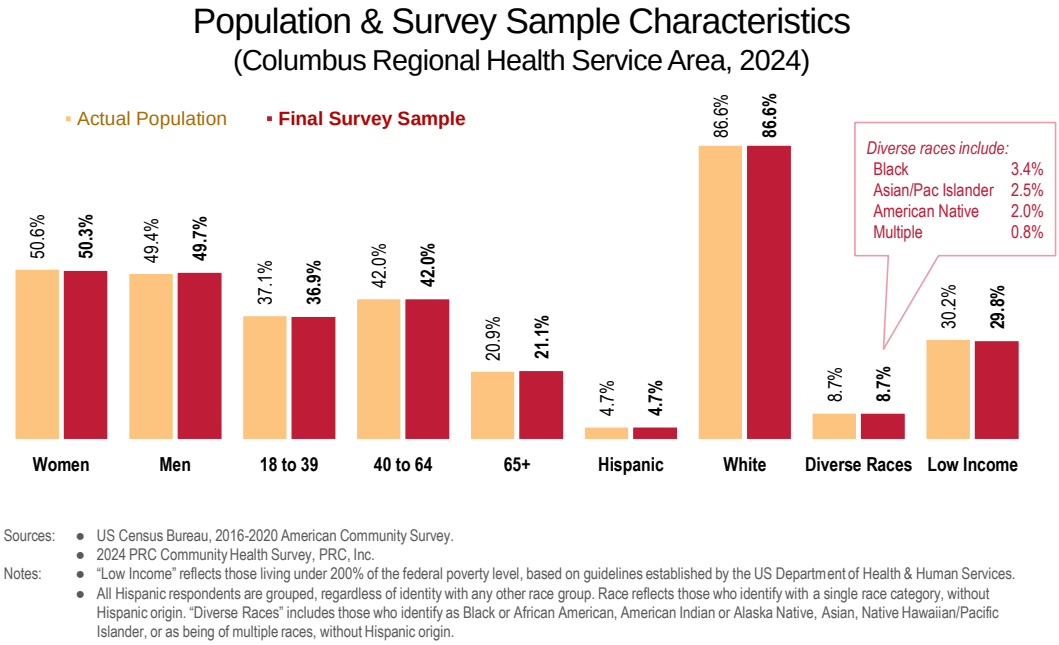
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 1,058 respondents answered a certain question with a "yes," it can be asserted that between 8.1% and 11.9% (10% ± 1.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.9% and 53.1% (50% ± 3.1%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses might contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics might have been slightly oversampled, might contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Columbus Regional Health Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2024 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Columbus Regional Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 147 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	10
Public Health Representatives	8
Other Health Providers	35
Social Services Providers	12
Other Community Leaders	82

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- ACT Research
- Action Team Coordinator
- Advocates for Children
- Alliance for Substance Abuse Progress
- Bartholomew Consolidated School Corporation
- Bartholomew County Council
- Bartholomew County Court Services
- Bartholomew County Health Department
- Bartholomew County Public Library
- Bartholomew County Sheriff's Department
- Brighter Days/Love Chapel
- CareSource
- Center for Counseling - The Sanctuary
- Centerstone
- Centra
- Children Inc.
- City of Columbus
- City of Columbus - Parks & Rec
- Columbus Area Arts Council
- Columbus Area Chamber of Commerce
- Columbus Behavioral Center
- Columbus City Council
- Columbus Police Department
- Columbus IN Pride, Inc.
- Columbus Regional Health
- Columbus Regional Health Foundation
- Columbus Regional Health - Healthy Communities
- Columbus Regional Health - Mental Health Matters
- Columbus Township
- Community Center of Hope, Inc.
- Community Education Coalition
- Council for Youth Development
- Cummins
- Ecumenical Assembly
- Faith in Place
- Family Service, Inc.
- Foundation for Youth
- Fresh Start Recovery (VOA)
- Gleaners Food Bank of Indiana
- Graham & Associates
- Human Services, Inc.
- Inclusive Options, LLC
- Indiana Department of Health
- Indiana University
- Indiana University Columbus
- Ivy Tech Community College
- Just Friends
- Landmark Columbus Foundation
- Lincoln Central Neighborhood Family Center
- Mill Race Center
- Mill Race Marathon
- Moms Demand Action
- National Alliance on Mental Illness
- New Hope Services, Inc.
- Northside Pediatrics
- Our Hospice of South Central Indiana
- Rau Family Medicine
- Salvation Army
- SIHO
- Su Casa of Columbus
- The Arc Bartholomew County
- The Republic
- Thrive Alliance
- Turning Point Domestic Violence Services
- United Way of Bartholomew County
- White River Broadcasting

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Columbus Regional Health Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data for Bartholomew, Jackson, and Jennings counties.

Benchmark Comparisons

Trending

Similar surveys were administered in the Columbus Regional Health Service Area in 1996, 2000, 2003, 2006, 2009, 2012, 2015, 2018, and 2021 by PRC on behalf of Columbus Regional Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Indiana Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After receiving feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be individually identifiable or might not comprise a large-enough sample for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Columbus Regional Health made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Columbus Regional Health had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Columbus Regional Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	7
Part V Section B Line 3b Demographics of the community	35
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	182
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	14
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	15
Part V Section B Line 3h The process for consulting with persons representing the community's interests	9
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	190

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process. **Here, these Areas of Opportunity are presented alphabetically rather than in order of importance.**

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Cost of Prescriptions – Appointment Availability – Lack of Transportation ▪ Primary Care Physician Ratio ▪ Aware of VIMCare Clinic at Columbus Regional Hospital
CANCER	▪ Leading Cause of Death ▪ Lung Cancer Deaths ▪ Cancer Prevalence
DIABETES	▪ Diabetes Prevalence ▪ Kidney Disease Deaths
DISABLING CONDITIONS	▪ Activity Limitations ▪ Caregiving
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ High Blood Pressure Prevalence ▪ High Blood Cholesterol Prevalence ▪ Overall Cardiovascular Risk
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths ▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Motor Vehicle Crash Deaths ▪ Forced Sexual Activity ▪ Water Safety Instruction [Children]

— continued on the following page —

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Suicide Deaths ▪ "Fair/Poor" Ease of Obtaining Services ▪ Mental Health Provider Ratio ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Meeting Physical Activity Guidelines ▪ Children's Physical Activity ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity ▪ Workplace Support for Healthy Living [Employed Adults] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
ORAL HEALTH	▪ Regular Dental Care [Adults]
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Pneumonia/Influenza Deaths
SUBSTANCE USE	▪ Unintentional Drug-Induced Deaths ▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

On September 5, 2024 Columbus Regional Health convened a group of providers and other community leaders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for the community, based on findings of this Community Health Needs Assessment (CHNA). PRC began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), an online voting platform was used in which each participant was able to register their ratings using a mobile device or web browser.

The participants were asked to evaluate each health issue along two criteria:

SCOPE & SEVERITY ► The first rating was to gauge the magnitude of the problem in consideration of the following:

- How many people are affected?
- How does the local community data compare to state or national levels, or Healthy People 2030 targets?
- To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered using a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

ABILITY TO IMPACT ► A second rating was designed to measure the perceived likelihood of having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Mental Health
2. Nutrition, Physical Activity & Weight
3. Substance Use
4. Heart Disease & Stroke
5. Diabetes
6. Access to Health Care Services
7. Infant Health & Family Planning
8. Tobacco Use
9. Cancer
10. Injury & Violence
11. Respiratory Disease
12. Disabling Conditions
13. Oral Health

Hospital Implementation Strategy

Columbus Regional Health will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, Columbus Regional Health Service Area results are shown in the larger, gray column.

The columns to the left of the Columbus Regional Health Service Area column provide comparisons among the three county areas, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the combined opposing areas.

The columns to the right of the Columbus Regional Health Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Columbus Regional Health Service Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

For Jennings and Jackson counties, survey data reflect only those ZIP Codes surveyed; for secondary data, the findings reflect the entirety of these counties.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 1996 (or earliest available data). Note that survey data reflect the ZIP Code-defined Columbus Regional Health Service Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Local secondary data reflect county-level data.

SOCIAL DETERMINANTS	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			TREND
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	
Linguistically Isolated Population (Percent)	2.0	0.0	3.4	2.0 [County-Level Data]	1.7	3.9		
Population in Poverty (Percent)	11.5	13.9	12.5	12.2 [County-Level Data]	12.3	12.5	8.0	
Children in Poverty (Percent)	14.0	19.2	16.2	15.5 [County-Level Data]	16.1	16.7	8.0	
No High School Diploma (Age 25+, Percent)	8.2	11.2	10.0	9.2 [County-Level Data]	10.0	10.9		
Unemployment Rate (Age 16+, Percent)	2.9	3.4	2.8	3.0 [County-Level Data]	3.4	3.5		
% Worry/Stress Over Rent/Mortgage in Past Year	32.4	34.1	27.6	31.5		45.8		
% Unhealthy/Unsafe Housing Conditions	11.0	12.4	12.0	11.5		16.4		
% Homeless at Some Point in the Past Year	3.5	3.4	1.7	3.0				
Population With Low Food Access (Percent)	36.4	25.2	33.0	33.3 [County-Level Data]	28.7	22.2		
% Food Insecure	29.1	33.5	22.9	28.3		43.3		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

OVERALL HEALTH	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	17.8	23.5	28.0	21.0	19.3	15.7		13.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	6.5	9.6	2.0	5.9	8.8	8.1	7.6	11.7
% [Insured] Went Without Coverage in the Past Year	7.0	8.7	4.7	6.7				7.5
% Difficulty Accessing Health Care in Past Year (Composite)	44.6	44.3	30.4	41.2		52.5		
% Cost Prevented Physician Visit in Past Year	15.5	7.9	9.8	13.0		21.6		12.7
% Cost Prevented Getting Prescription in Past Year	15.7	20.9	12.5	15.8		20.2		12.1
% Difficulty Getting Appointment in Past Year	27.5	15.6	15.7	22.9		33.4		9.1
% Inconvenient Hrs Prevented Dr Visit in Past Year	19.3	17.1	11.4	17.1		22.9		
% Difficulty Finding Physician in Past Year	14.3	16.0	7.1	12.9		22.0		

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Transportation Hindered Dr Visit in Past Year	8.4	14.5	15.0	**10.9**		18.3		5.8
% Language/Culture Prevented Care in Past Year	2.4	3.5	0.7	**2.2**		5.0		1.8
% Difficulty Getting Child's Health Care in Past Year				**6.6**		11.1		10.0
% [Child 0-17] Routine Checkup in Past Year				**92.0**		77.5		91.0
Primary Care Doctors per 100,000	69.9	40.0	63.3	**62.8** [County-Level Data]	66.7	76.4		
% Have a Specific Source of Ongoing Care	77.6	79.5	77.4	**77.8**		69.9	84.0	
% Aware of the VIMCare Clinic at CRH	50.2	22.2	17.4	**38.2**				66.4

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

CANCER	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)	150.7	206.0	166.7	**165.4** [County-Level Data]	163.9	146.5	122.7	196.7
Lung Cancer Deaths per 100,000 (Age-Adjusted)				**46.9** [County-Level Data]	42.7	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)				**14.9** [County-Level Data]	20.2	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)				**20.5** [County-Level Data]	19.8	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)				**15.4** [County-Level Data]	14.6	13.1	8.9	
% Skin Cancer	9.9	9.5	8.2	**9.4**				6.0
% Cancer (Other Than Skin)	8.5	5.9	7.3	**7.8**				4.4
% [Women 50-74] Breast Cancer Screening	88.1			**86.2**	78.1	64.0	80.5	74.3
% [Women 21-65] Cervical Cancer Screening	74.6			**74.3**	47.5	75.4	84.3	77.6

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

DIABETES	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000 (Age-Adjusted)	9.1	25.3	24.0	16.4 [County-Level Data]	26.9	22.6		19.8
% Diabetes/High Blood Sugar	10.6	18.8	22.1	14.5	12.7	12.8		7.4
Kidney Disease Deaths per 100,000 (Age-Adjusted)	18.8		13.9	17.4 [County-Level Data]	17.4	12.8		18.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DISABLING CONDITIONS	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Activity Limitations	26.6	40.7	27.8	29.0		27.5		19.0
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	30.0		15.7	22.5 [County-Level Data]	33.1	30.9		35.4
% Caregiver to a Friend/Family Member	29.6	30.3	21.5	27.8		22.8		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HEART DISEASE & STROKE	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000 (Age-Adjusted)	156.3	199.8	188.7	173.0 [County-Level Data]	181.1	164.4	127.4	178.6
Stroke Deaths per 100,000 (Age-Adjusted)	35.2	58.6	45.6	42.2 [County-Level Data]	40.3	37.6	33.4	49.8
% High Blood Pressure	41.3	50.5	60.7	47.2	34.5	40.4	42.6	20.4
% High Cholesterol	32.5	40.3	37.0	34.8		32.4		25.3
% 1+ Cardiovascular Risk Factor	85.7	92.2	96.2	89.2		87.8		84.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Teen Births per 1,000 Females 15-19	23.3	37.9	40.2	30.8 [County-Level Data]	20.2	16.6		
Low Birthweight (Percent of Births)	7.8	7.2	6.7	7.4 [County-Level Data]	8.3	8.3		
Infant Deaths per 1,000 Births	7.0	8.0	5.8	7.0 [Bartholomew County Data]	6.8	5.6	5.0	9.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INJURY & VIOLENCE	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	57.4	81.4	82.6	69.0 [County-Level Data]	59.4	51.6	43.2	47.1
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	14.9		23.0	18.8 [County-Level Data]	12.6	11.4	10.1	
% "Always" Use a Seat Belt	87.7	81.2	83.3	85.7				68.3
% [Age 5-17] Child "Always" Wears a Bike Helmet				44.6				22.5
[65+] Fall-Related Deaths per 100,000 (Age-Adjusted)				37.5 [County-Level Data]	45.6	67.1	63.4	
Homicide Deaths per 100,000 (Age-Adjusted)	2.6			2.8 [County-Level Data]	6.7	5.9	5.5	
% Firearm in or Around the Home	43.9	57.0	55.5	48.5				43.9
% [Households w/ Firearms] Gun is Unlocked/Loaded	19.9			21.1				22.9
% [Households w/Children] Firearm in or Around the Home				41.3				56.4
Violent Crimes per 100,000	106.5	188.5	224.8	155.4 [County-Level Data]	391.4	416.0		
% Victim of Intimate Partner Violence/Past 3 Years	6.1	5.4	3.1	5.3				3.9
% Victim of Emotional Harm by Intimate Partner/Past 3 Years	13.5	17.2	11.3	13.6				

INJURY & VIOLENCE (continued)	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Forced Into Sexual Activity in the Past 3 Years	2.5	3.1	7.5	3.8				1.1
% [Parents] Child Has Received Water Safety Instruction				69.8				78.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

MENTAL HEALTH	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	25.2	32.9	16.1	24.2		24.4		15.6
% Symptoms of Depression	33.6	37.0	27.5	32.7				30.9
% Diagnosed Depression	40.2	40.7	25.4	36.8	22.8	30.8		26.9
% Typical Day Is "Extremely/Very" Stressful	20.5	9.6	9.9	16.5		21.1		
Suicide Deaths per 100,000 (Age-Adjusted)	14.6	23.5	18.9	17.5 [County-Level Data]	15.1	13.9	12.8	14.3
% Considered Suicide in Past Year	10.1	9.5	3.2	8.4				6.8
% Ease of Obtaining Mental Health Services is "Fair/Poor"	44.0	40.5	35.8	41.6				31.2

MENTAL HEALTH (continued)	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Mental Health Providers per 100,000	183.0	113.0	89.0	143.2 [County-Level Data]	200.0	313.7		
% Have Sought Help for Mental Health in the Past Year	26.0	19.3	24.9	24.7				
% Receiving Mental Health Treatment	29.8	44.0	24.1	30.6		21.9		
% Unable to Get Mental Health Services in Past Year	13.9	6.4	5.0	10.7		13.2		3.8
% [Age 5-17] Child Has "Fair/Poor" Mental Health				17.5		14.4		22.5
% [Age 5-17] Child Needed Mental Health Svcs/Past Year				19.3				23.4
% [Age 5-17] Child Rec'd Treatment in the Past Year				17.3				22.5
% [Age 5-17] Child Had Symptoms of Depression				11.9		14.2		6.8
% [Age 5-17] Child Has Been Diagnosed with Depression				11.3		11.7		15.0
% [Age 5-17] Child Has Been Diagnosed with Anxiety				27.4		22.5		23.9
% [Age 5-17] Bullied on School Property in the Past Year				23.0		27.9		30.1

MENTAL HEALTH (continued)	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% [Age 5-17] Bullied in Person Outside School Property				12.9				13.1
% [Age 5-17] Electronically Bullied in the Past Year				13.9		15.3		9.2
% [Parents] Aware of Local Resources for Mental Health				72.9		67.5		70.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	27.6	32.4	32.0	29.4		30.0		
% 5+ Servings of Fruits/Vegetables Yesterday	10.0	7.4	6.9	8.8				11.3
% Eat 5+ Weekly Meals Together as a Family	44.0	38.6	40.7	43.3				
% No Leisure-Time Physical Activity	28.0	33.8	39.6	31.6	27.5	30.2	21.8	28.2
% Meet Physical Activity Guidelines	24.3	17.7	21.0	22.5	21.1	30.3	29.7	19.6
% [Child 2-17] Physically Active 1+ Hours per Day				51.5		27.4		61.1

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% [Age 5-17] Child Spends 3+ Hours on Screen Time				41.6		71.9		43.4
Recreation/Fitness Facilities per 100,000	18.3		6.5	11.5 [County-Level Data]	10.5	14.8		
% Overweight (BMI 25+)	71.5	73.5	81.2	74.1	71.0	63.3		52.9
% Obese (BMI 30+)	38.2	40.6	70.5	46.1	37.7	33.9	36.0	16.8
% [Employed] Workplace is More Supportive of Healthy Lifestyles				70.8				82.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ORAL HEALTH	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Dental Visit in Past Year	65.5	54.7	67.5	64.3	63.1	56.5	45.0	70.4
% [Child 2-17] Dental Visit in Past Year				82.1		77.8	45.0	79.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

RESPIRATORY DISEASE	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000 (Age-Adjusted)	44.9	80.2	59.8	**55.5** [County-Level Data]	55.7	38.1		67.0
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	15.8		19.0	**15.9** [County-Level Data]	12.7	13.4		11.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SEXUAL HEALTH	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	87.8	34.8	144.5	**95.1** [County-Level Data]	217.0	382.2		
Chlamydia Incidence per 100,000	363.8	280.9	316.9	**335.4** [County-Level Data]	510.7	495.5		
Gonorrhea Incidence per 100,000	121.2	58.4	73.8	**96.2** [County-Level Data]	212.8	214.0		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SUBSTANCE USE	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	8.6			8.8 [County-Level Data]	13.1	11.9		8.4
Cirrhosis/Liver Disease Deaths per 100,000 (Age-Adjusted)	10.4	21.6	15.2	13.8 [County-Level Data]	15.4	12.5	10.9	
% Excessive Drinking	16.4	6.5	9.8	13.3	15.8	34.3		13.7
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)	26.0	40.8	37.8	31.8 [County-Level Data]	26.6	21.0		12.5
% Ever Sought Help for Alcohol or Drug Problem	6.5	8.0	2.2	5.7		6.8		
% Personally Impacted by Substance Use	46.6	38.9	41.5	44.1		45.4		42.0
% Know Where to Access Substance Use Treatment	64.0	72.6	63.7	65.3				65.9
% Family Member Unable to Access Addiction Treatment	6.9	4.4	8.2	6.8				8.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

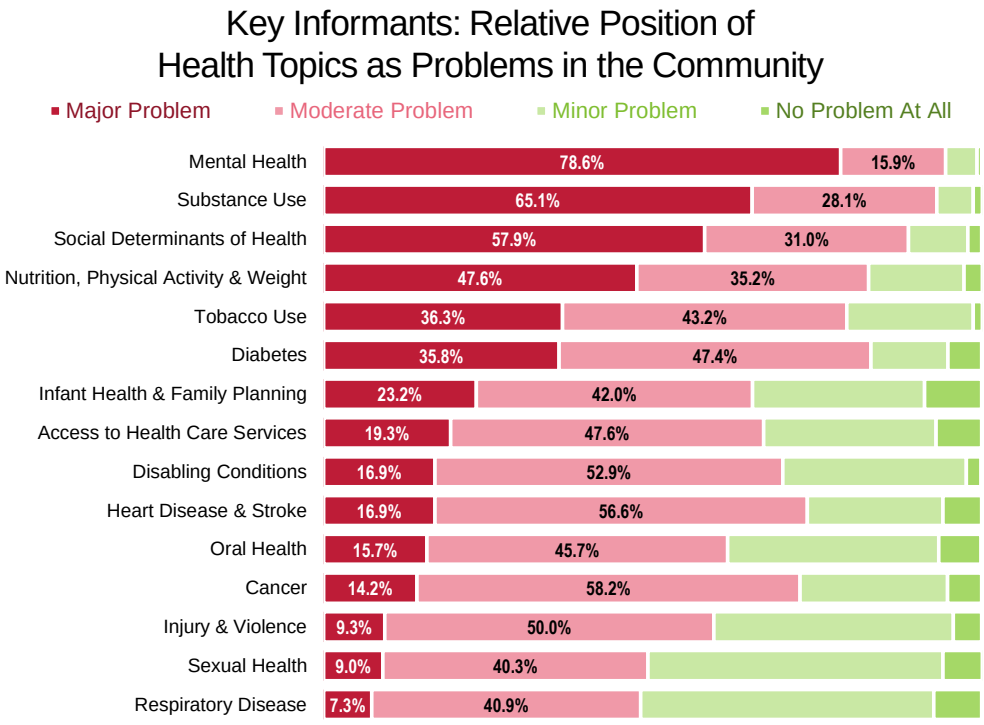
TOBACCO USE	DISPARITY AMONG SUBAREAS			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	14.1	30.0	10.8	**15.7**	16.2	23.9	6.1	26.4
% Someone Smokes at Home	11.2	23.1	10.8	**12.9**		17.7		29.3
% Use Vaping Products	8.7	13.4	9.4	**9.7**	8.1	18.5		3.2
% Aware of the Indiana Tobacco Quit Line	55.4	61.0	60.8	**57.5**				52.7

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 15 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The three-county area that encompasses the Columbus Regional Health Service Area is 1,293.51 square miles and houses a total population of 156,193 residents, according to latest census estimates.

Total Population
(Estimated Population, 2018-2022)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Bartholomew County	82,371	406.94	202
Jennings County	27,610	376.60	73
Jackson County	46,212	509.98	91
CRH Service Area	**156,193**	**1,293.51**	**121**
Indiana	6,784,403	35,825.89	189
United States	331,097,593	3,533,269.34	94

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Population Change 2010-2020

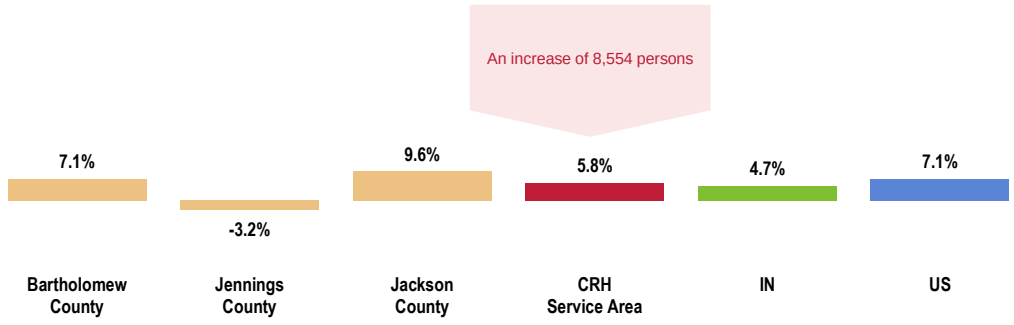
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2010 and 2020 US Censuses, the population of the Columbus Regional Health Service Area increased by 8,554 persons, or 5.8%.

BENCHMARK ► Higher than the state increase.

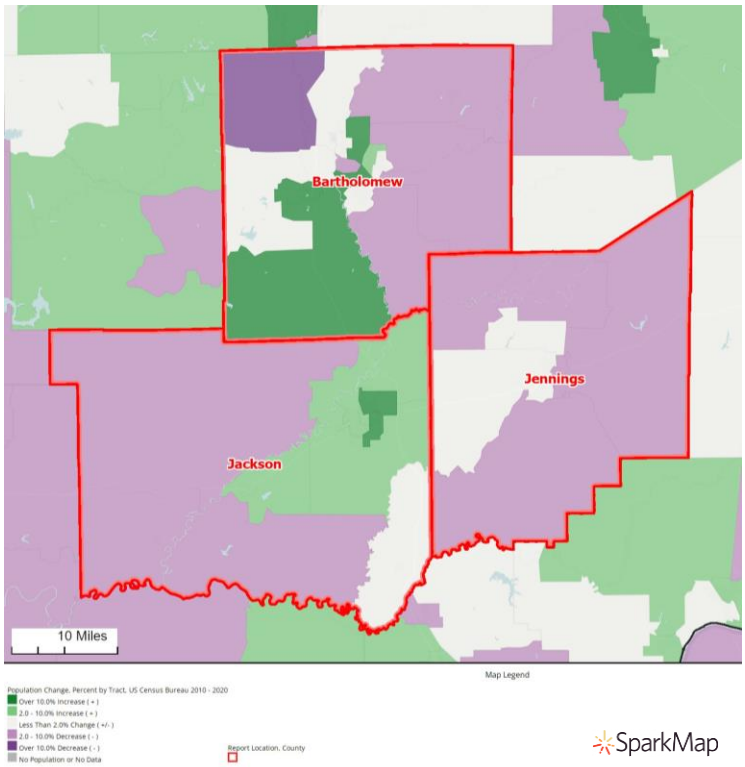
DISPARITY ► Jennings County shows a loss in population.

Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

This map shows the areas of greatest increase or decrease in population between 2010 and 2020.



Urban/Rural Population

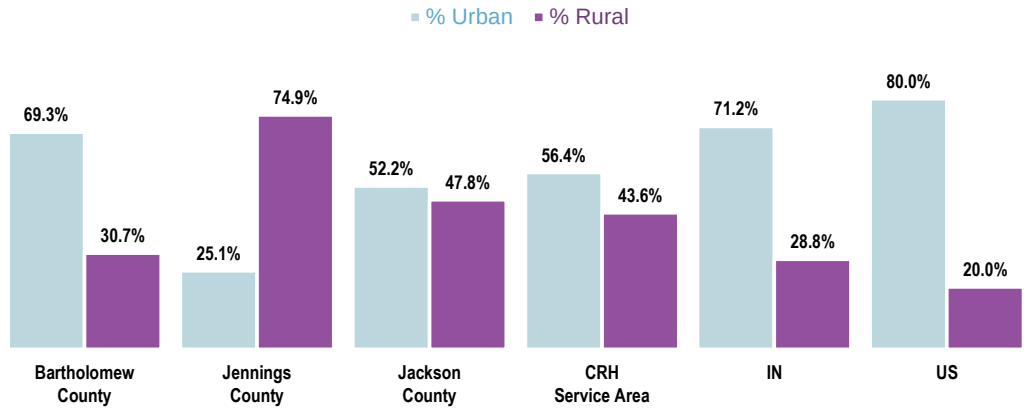
Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

The Columbus Regional Health Service Area is predominantly urban, with 56.4% of the population living in areas designated as urban.

BENCHMARK ► However, the service area is more rural than the state and nation.

DISPARITY ► Unlike Bartholomew and Jackson counties, Jennings County is mostly rural.

Urban and Rural Population
(2020)



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Age

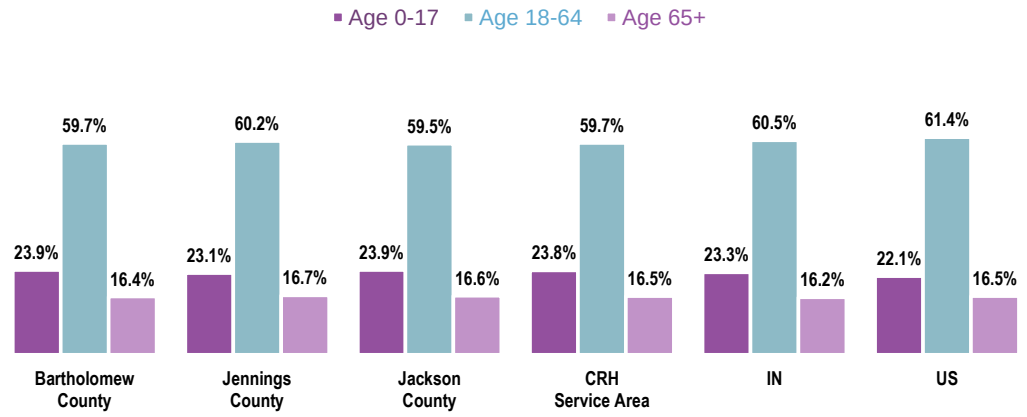
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

In the Columbus Regional Health Service Area, 23.8% of the population are children age 0-17; another 59.7% are age 18 to 64, while 16.5% are age 65 and older.

BENCHMARK ► Similar to state and national proportions.

DISPARITY ► Age proportions are similar across the three counties.

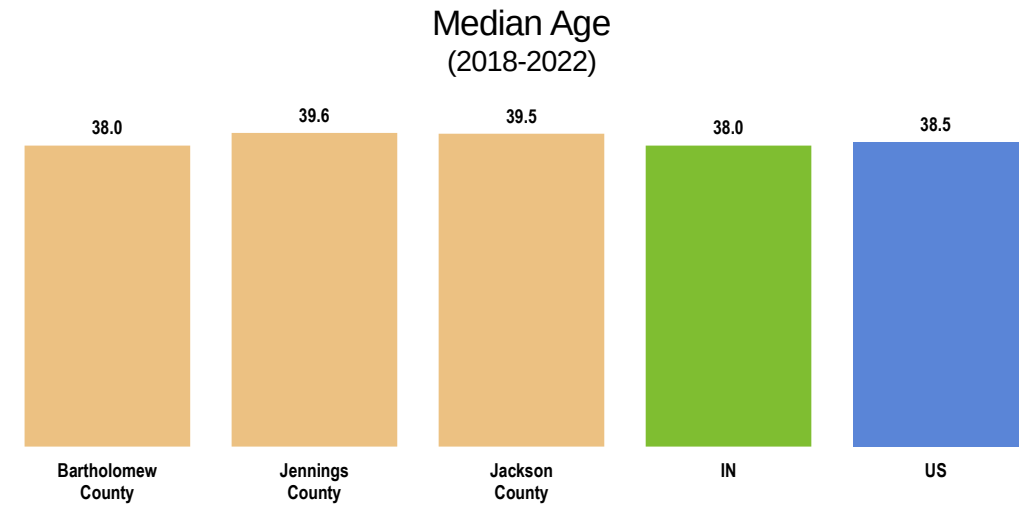
Total Population by Age Groups
(2018-2022)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

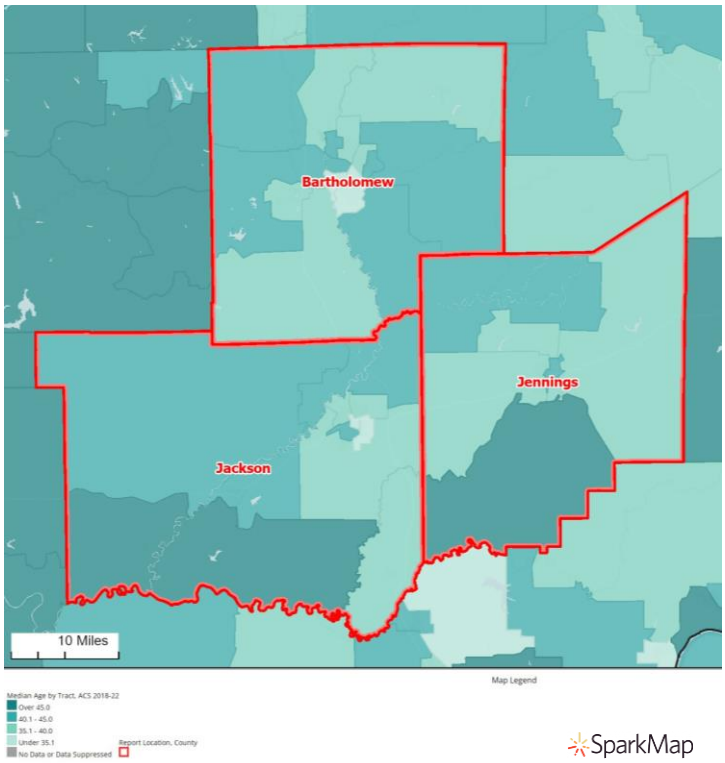
Median Age

Jennings and Jackson counties are "older" than the state and the nation in that their median ages are higher. (A composite median is not available for the Columbus Regional Health Service Area as a whole.)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age by census tract throughout the Columbus Regional Health Service Area.



Race & Ethnicity

Race

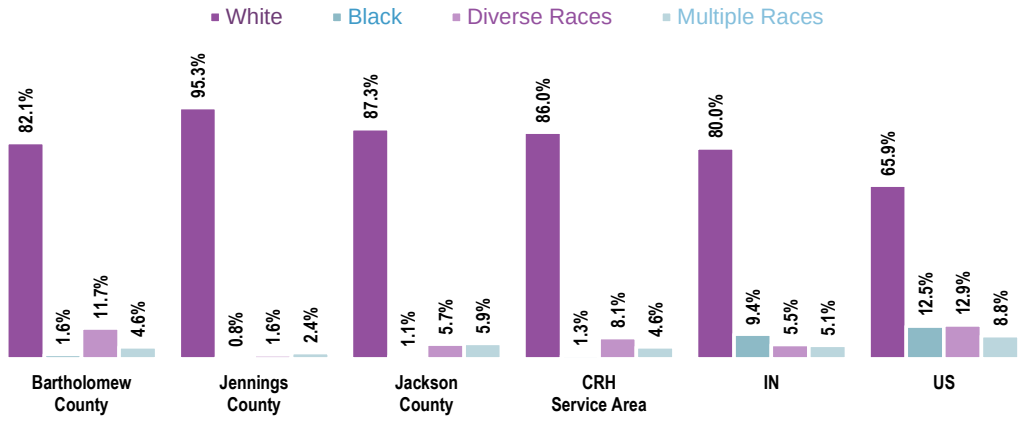
Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

In looking at race independent of ethnicity (Hispanic or Latino origin), 86.0% of residents of the Columbus Regional Health Service Area are White and 1.3% are Black.

BENCHMARK ► Less diverse than the state and nation.

DISPARITY ► Bartholomew County is more diverse than Jennings and Jackson counties.

Total Population by Race Alone
(2018-2022)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

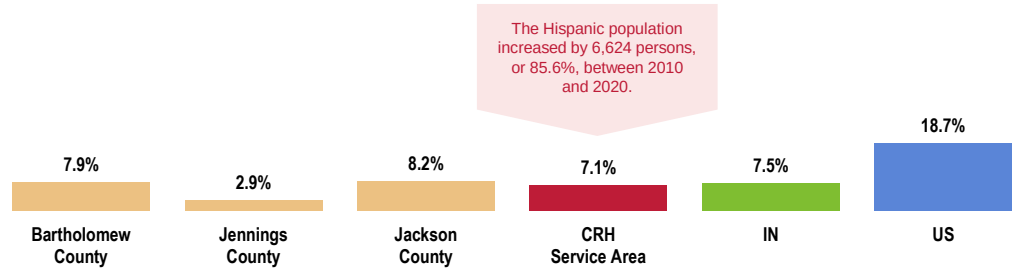
Ethnicity

A total of 7.1% of Columbus Regional Health Service Area residents are Hispanic or Latino.

BENCHMARK ► Much lower than found across the US.

DISPARITY ► Higher in Bartholomew and Jackson counties.

Hispanic Population
(2018-2022)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

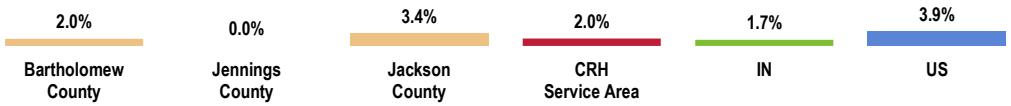
Linguistic Isolation

A total of 2.0% of the Columbus Regional Health Service Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

BENCHMARK ► Higher than found statewide but lower than found across the US.

DISPARITY ► Highest in Jackson County.

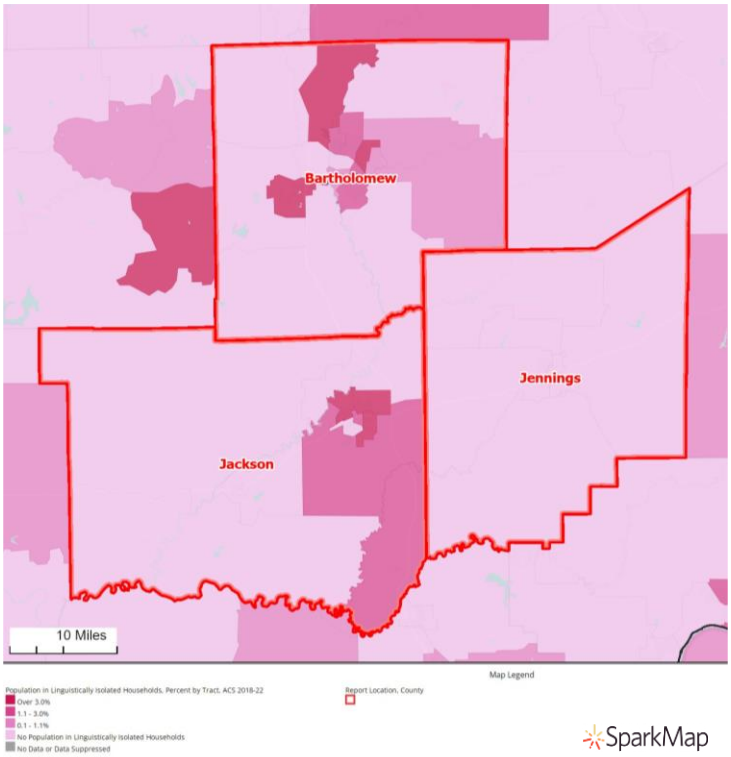
Linguistically Isolated Population
(2018-2022)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speaks a non-English language and speak English "very well."

Note the following map illustrating linguistic isolation throughout the service area.



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to overall health.

The latest census estimate shows 12.2% of the Columbus Regional Health Service Area total population living below the federal poverty level.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

Among just children (ages 0 to 17), this percentage in the Columbus Regional Health Service Area is 15.5% (representing an estimated 5,568 children).

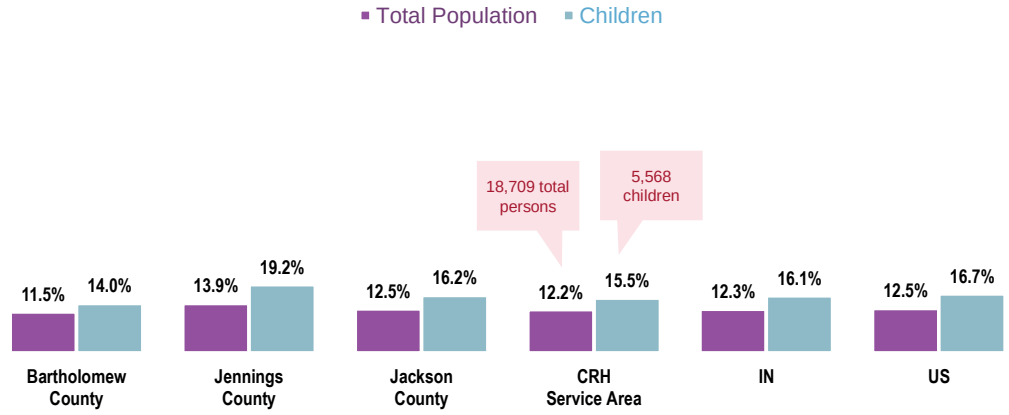
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Higher in Jennings County.

Percent of Population in Poverty

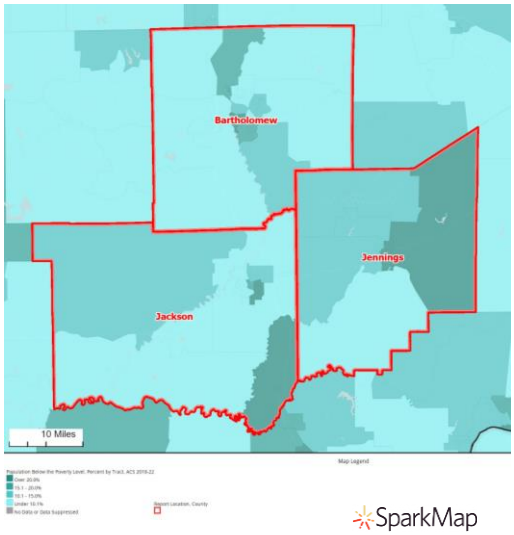
(2018-2022)

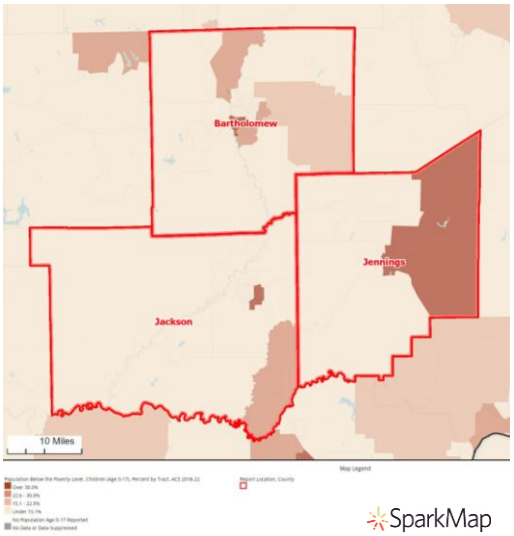
Healthy People 2030 = 8.0% or Lower



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

The following maps highlight concentrations of persons living below the federal poverty level.





Education

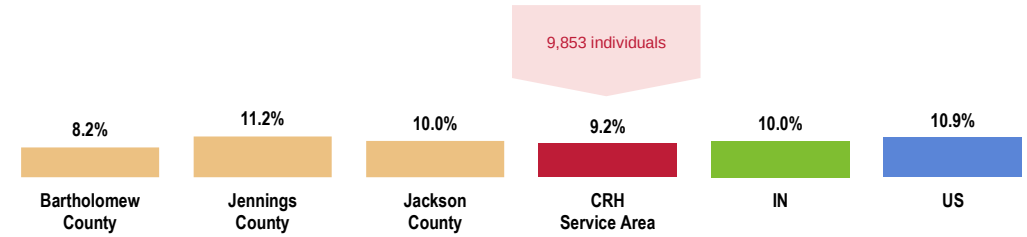
Among the Columbus Regional Health Service Area population age 25 and older, an estimated 9.2% (over 9,800 people) do not have a high school education.

BENCHMARK ► Lower than the national finding.

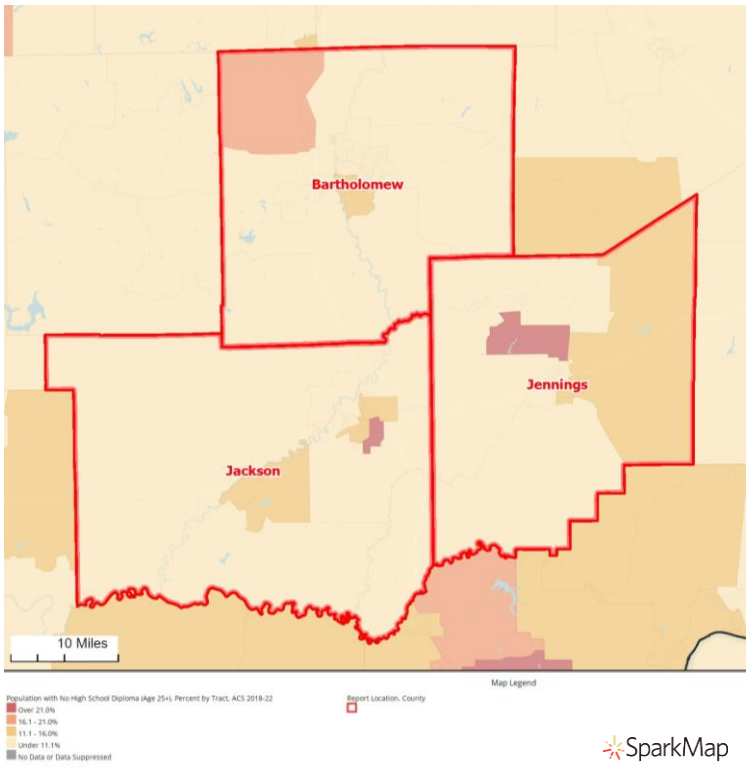
DISPARITY ► Lowest in Bartholomew County.

Population With No High School Diploma

(Adults Age 25 and Older; 2018-2022)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

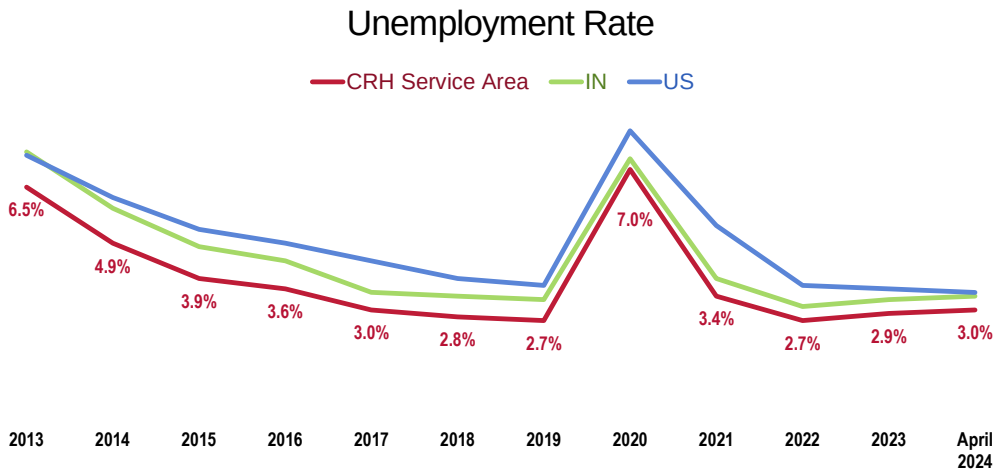


Employment

According to data derived from the US Department of Labor, the unemployment rate in the Columbus Regional Health Service Area as of April 2024 was 3.0%.

BENCHMARK ► Lower than the national rate.

TREND ► Following significant increases in 2020 (during the COVID-19 pandemic), unemployment has dropped below pre-pandemic levels and is much lower than found a decade ago.

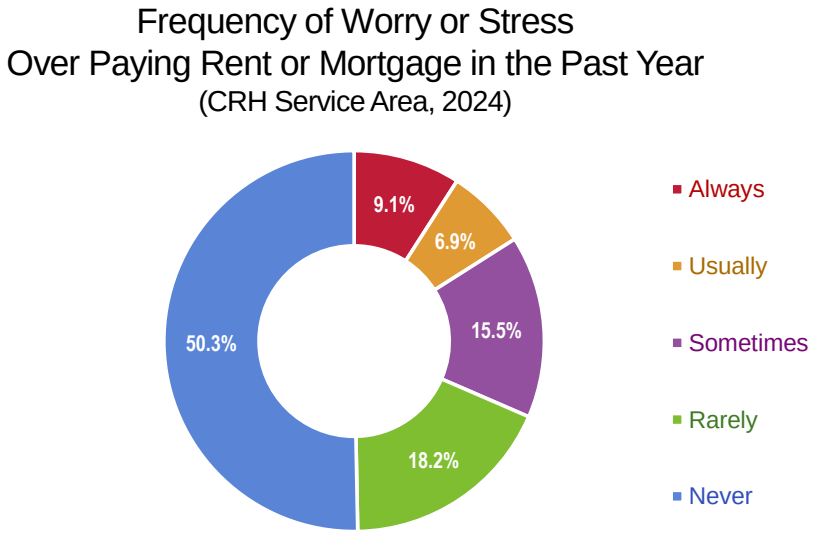


Sources: ● US Department of Labor, Bureau of Labor Statistics.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).
Notes: ● Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Housing

Housing Insecurity

Most surveyed adults rarely, if ever, worry about the cost of housing.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

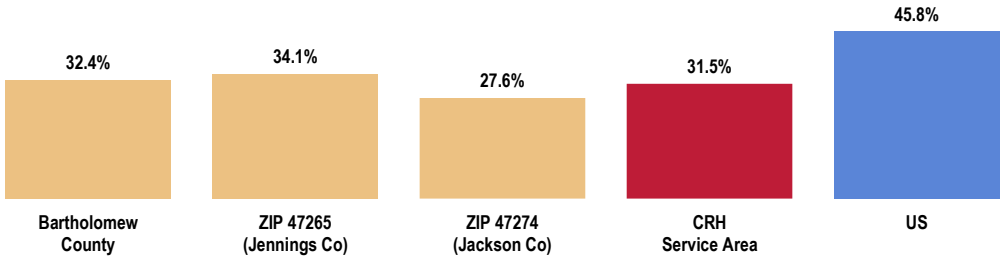
NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

However, a considerable share (31.5%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

BENCHMARK ► Lower than found across the US.

DISPARITY ► More often reported among adults younger than 65, lower-income households (especially), people of color, LGBTQ+ respondents, and renters (especially).

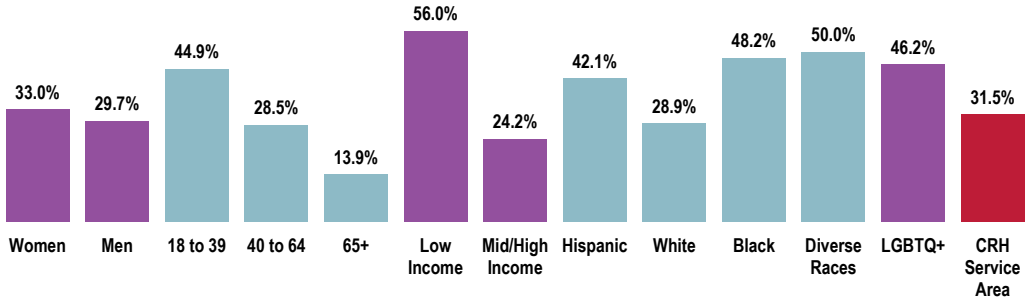
"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(CRH Service Area, 2024)

Among homeowners	22.5%
Among renters	51.0%



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: • Asked of all respondents.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

INCOME & RACE/ETHNICITY

INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2023 guidelines place the poverty threshold for a family of four at $30,000 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Data are also detailed for individuals identifying with a race category, without Hispanic origin. "White" reflects those who identify as White alone, without Hispanic origin. "Black" reflects those who identify as Black or African American alone, without Hispanic origin. "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

Unhealthy or Unsafe Housing

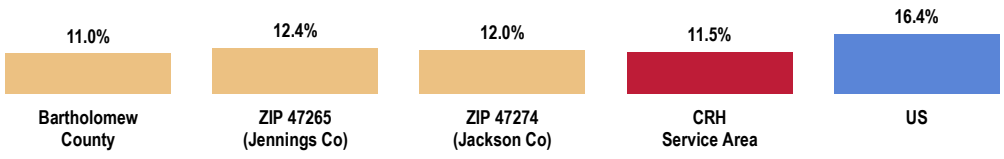
A total of 11.5% of Columbus Regional Health Service Area residents report living in unhealthy or unsafe housing conditions during the past year.

BENCHMARK ► Lower than the national percentage.

DISPARITY ► More often reported among women, adults younger than 65, those with lower incomes, LGBTQ+ respondents, and renters.

Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year

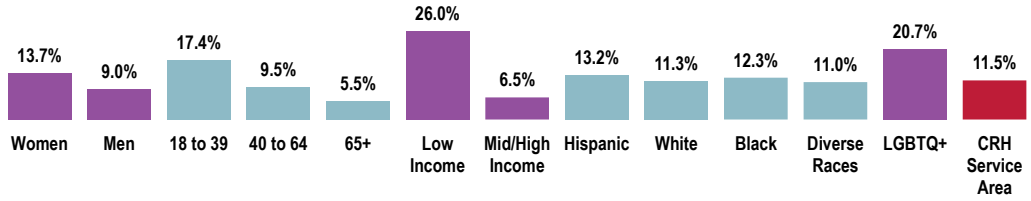


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(CRH Service Area, 2024)

Among homeowners	5.8%
Among renters	20.5%



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
Notes: • Asked of all respondents.
• Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Housing Instability

"Has there been any time in the past 12 months when you were living on the street, in a car, or in a temporary shelter?"

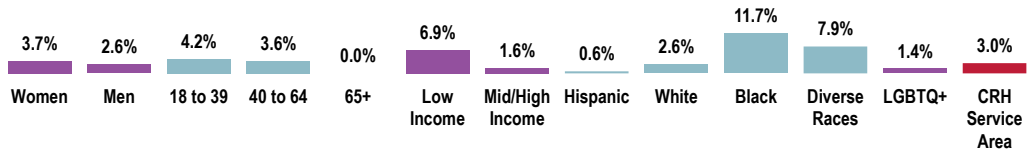
A total of 3.0% of respondents report having been homeless at some point in the past 12 months.

DISPARITY ► More often reported among adults younger than 65, those with lower incomes, and non-Hispanic respondents.

Was Homeless at Some Point in the Past Year

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 316]
Notes: • Asked of all respondents.
• Includes those who were living on the street, in a car, or in a temporary shelter.

Was Homeless at Some Point in the Past Year
(CRH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 316]

Notes:
- Asked of all respondents.
- Includes those who were living on the street, in a car, or in a temporary shelter.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Food Access

Low Food Access

Low food access is defined as living more than 1 mile (in urban areas, or 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

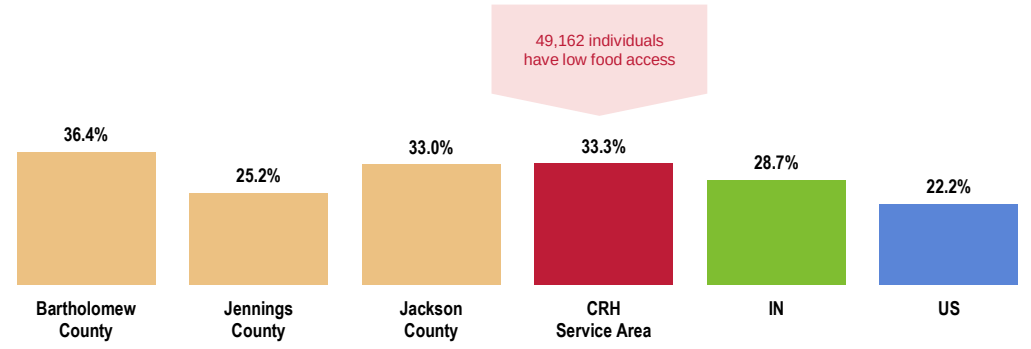
RELATED ISSUE
See also Difficulty Accessing Fresh Produce in the *Nutrition, Physical Activity & Weight* section of this report.

US Department of Agriculture data show that 33.3% of the Columbus Regional Health Service Area population (representing over 49,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

BENCHMARK ► Worse than the national finding.

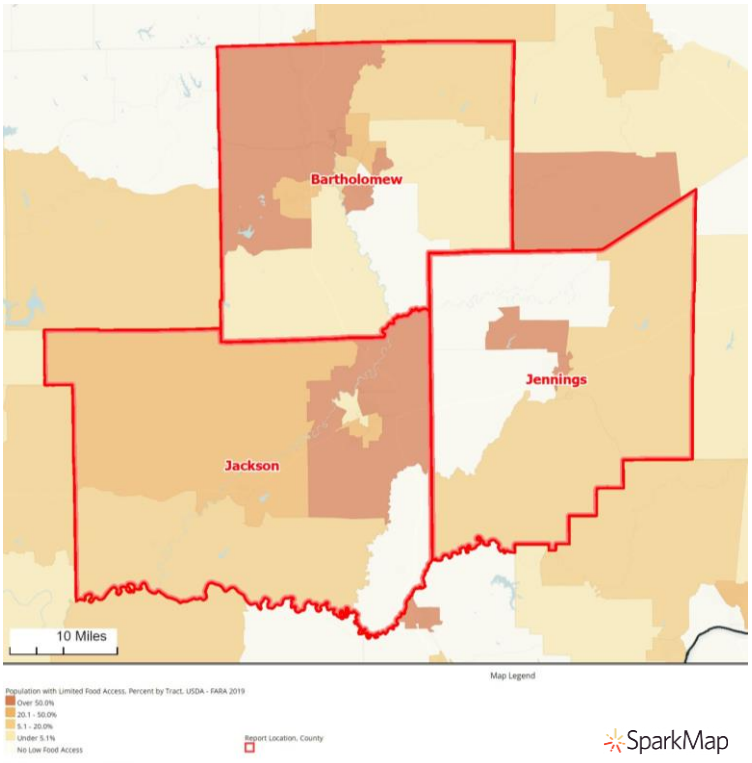
DISPARITY ► Lowest in Jennings County.

Population With Low Food Access
(2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.



Food Insecurity

Overall, 28.3% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

BENCHMARK ► Much lower than the US percentage.

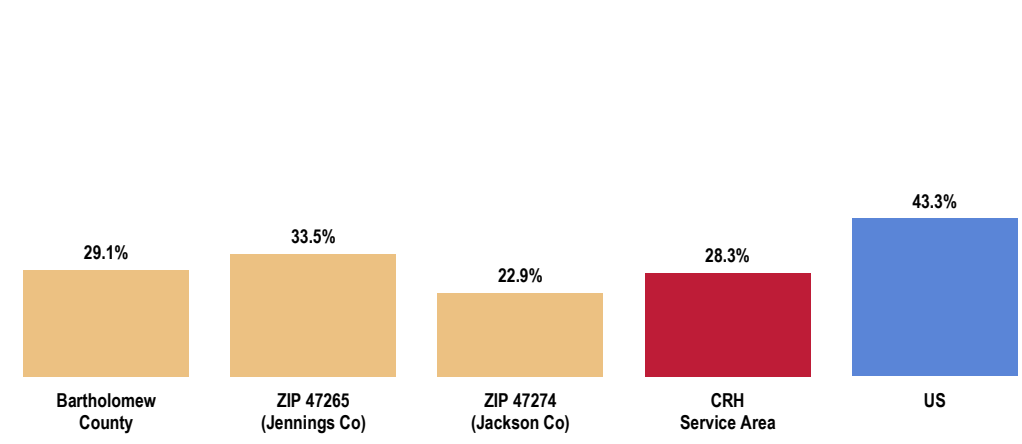
DISPARITY ► More often reported among women, adults younger than 65, lower-income respondents, people of color, and LGBTQ+ respondents.

Surveyed adults were asked: "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "often true," "sometimes true," or "never true" for you in the past 12 months:

I worried about whether our food would run out before we got money to buy more.

The food that we bought just did not last, and we did not have money to get more."

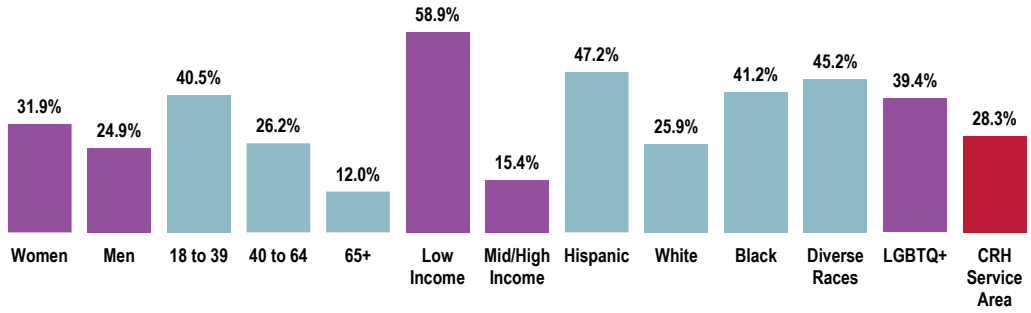
Those answering "often" or "sometimes" true for either statement are considered to be food insecure.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(CRH Service Area, 2024)

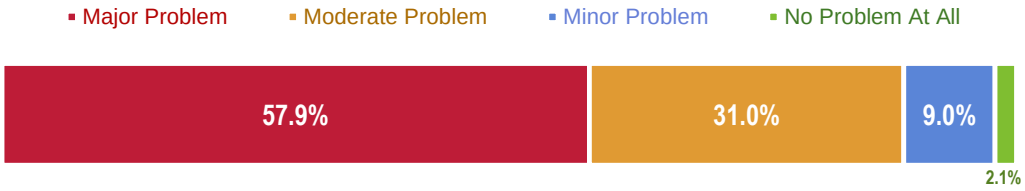


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: • Asked of all respondents.
• Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Key Informant Input: Social Determinants of Health

The greatest share of key informants taking part in an online survey characterized *Social Determinants of Health* as a "major problem" in the community.

Perceptions of Social Determinants of Health as a Problem in the Community
(Key Informants; CRH Service Area, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Housing

> Housing is probably one of the biggest barriers to health. We have a lot of individuals who struggle finding affordable and safe housing. – Community Leader
>
> With the cost of living so high, many are struggling with housing costs and the cost of food/lack of transportation. – Health Provider
>
> Affordable housing is an issue for the families we serve. – Community Leader
>
> Lack of housing is a huge issue. – Community Leader
>
> Housing is a major issue in our community due to lack of affordable housing, income-based housing, second chance, low-barrier landlords. Individuals with criminal history and evictions have difficulty accessing resources for affordable housing. – Social Services Provider
>
> Lack of housing/affordable housing, low wages, and lack of transportation to/from jobs and services are major barriers for people that are impacting their physical and mental well-being. – Health Provider
>
> Affordable housing with prices increasing without pay increases creates challenges for many. – Community Leader

Not nearly enough low-income housing. – Community Leader

Housing is unaffordable for young people, older people on fixed incomes, and families with children. – Health Provider

The housing situation causes real health issues for many in our community. It's impossible to focus on your health when you can't find quality, affordable housing. – Health Provider

Safe, stable, and affordable housing is fundamental to personal well-being. Housing instability and homelessness also contribute to health disparities. Low income and poverty, conversely, are associated with increased stress, higher rates of disease, and reduced access to medical care and preventive services. Education affects health in several ways. The physical and social environments where people live play crucial roles in health. Social environments that foster strong community bonds can also support mental health and resilience. Discrimination based on race, ethnicity, gender, sexual orientation, age, disability, and other factors can lead to systemic inequalities in access to health care, education, employment, and housing. – Community Leader

High cost of living and lack of child care resources strain families and require multiple workers in a household to survive. This leaves little time for a person to focus on personal health, recreation, and connection to children and others. – Health Provider

Access to affordable housing, access to healthy/affordable nutrition, transportation barriers, health insurance barriers, mental health. – Health Provider

Affordable housing, access to affordable care, isolation, and community. – Health Provider

There is a lack of affordable housing in our community. There are food deserts in our community. Transportation is an issue for some, prohibiting them from getting a job or even going to doctor's appointments. – Health Provider

Affordable housing for those with mental health and SUD issues is a major problem due to inability to access/maintain higher-paying jobs; access to economic stability is limited due to individual history with felonies, lack of training for higher-paying jobs; lack of education due to long-term mental illness or addiction; discrimination/stigma towards people with SUD and mental illness limits opportunities. – Community Leader

Our community is struggling in every category of the social determinants of health. We don't have enough housing stock; our homeless and vulnerable populations aren't prioritized. Children deal with discrimination in schools, and their environments aren't always supportive of their development and well-being, such as having parents who are substance abusers, etc. Also, we have an income gap that is dividing the town, and it is felt throughout. – Health Provider

Due to having a larger number of employees that work at our organization that commute, we hear that AFFORDABLE housing is at a minimum. In researching housing for my elderly mother, there are very limited options. – Health Provider

Lack of safe, affordable housing, food deserts within counties, no reliable public transportation. – Health Provider

Affordable housing is a problem in this community, especially considering the size of the community. Opportunities for employment for people of all educational backgrounds feel limited. – Community Leader

Lack of affordable housing is a challenge we consistently hear talked about from our staff and those they serve. – Social Services Provider

Frequently, people are seen in our clinic with problems such as these and are unable to gain access to help with housing, day care, utility bills ... They are put on waitlists or are just unable to get help without being threatened that they will lose their electricity, water. – Social Services Provider

Housing in Bartholomew County is so expensive. If it comes to having money for rent or mortgage or money for mental health, people will use their money for housing. This is the same with the costs of food and other things people need to live. I am one of these people. My out-of-pocket costs for therapy are too large for me to pay and afford other living expenses. – Social Services Provider

Columbus is experiencing a housing crisis like never before in this community. If a person has no housing, then the likelihood that they are meeting other health needs is very slim. – Community Leader

Not enough housing. Food insecurity. – Community Leader

When you think about the location of our subsidized housing, then you notice there aren't affordable or free access to gyms, fresh food, or safe places for people to play. – Public Health Representative

Housing costs are very high and causing some people to have to choose between rent and medical bills. – Community Leader

HOUSING COSTS ARE TOO HIGH! – Health Provider

Lack of affordable housing. Quality housing. We have data from IUC proving that people in certain neighborhoods don't live as long as people in other neighborhoods. Way too many slumlords. – Community Leader

Equitable access to opportunity is a problem for many in our community, with those opportunities including affordable housing, livable incomes, educational attainment, and health services. Data accumulated within our county indicates that individuals with low socioeconomic status and/or Black/biracial or Latinx have a more difficult time accessing proper resources. Additional data indicates that there is a large disparity within census blocks in regard to life expectancy, largely based on socioeconomic status. – Community Leader

Affordable housing is a problem. – Social Services Provider

Lack of affordable housing – Health Provider

Housing remains a major issue. Many with mental health conditions are unable to find adequate, affordable, and/or safe housing. – Community Leader

There is a clear lack of affordable housing, especially for those individuals and families who are experiencing poverty. – Community Leader

Housing continues to be a critical issue for a disproportionate number of Bartholomew County residents. Rents are high, and Indiana has one of the most restrictive laws in favor of landlords. Those with a mental health or substance use disorder are at a great disadvantage. A prior history of eviction, disorganized living habits, relationship struggles, etc. create difficulty in maintaining Section 8, which takes a while to achieve and is very difficult to get back once lost. Housing First options have been introduced, but the community has not supported such efforts, even though they are best practice for the seriously mentally ill. Even though we are addressing mental health, the most severe cases remain most neglected. For those who cannot maintain employment, the application process for disability is a limiting barrier. Most people are unsuccessful without help, and providers direct people to disability lawyers. This is a dead end for many because the lawyer is not a caseworker. – Community Leader

Income/Poverty

Poverty is too high – there is a widening gap between the lowest-income households, working-class households, and upper middle/upper-income households. – Health Provider

Financially, people are struggling. There is no time to think beyond work, health care, and critical components of life. And lack of resources isn't allowing our community to properly care for themselves. We need to do better and encourage health in all elements of the community. One example, screens aren't good, but our kids are on them from too young of an age for too many hours a day in their school classrooms. It seems health is only afforded by the rich in our society. – Community Leader

Big gap of services for the low-income community and the immigrant community. – Social Services Provider

We have a high percentage of children at BCSC who qualify for free or reduced lunch (40% to 50%). We know many of our students have ACEs and experience trauma in their lives. And we have too many kids who are homeless and families with high mobility rates. Financial insecurity, trauma, mental health challenges, and homelessness all contribute to lower education outcomes and lower health outcomes. And, as is seen across the nation, we are seeing a significant drop in college-going rates (with college including short-term credentials, two-year degrees, and four-year degrees). Ensuring an equitable approach to ensuring all learners have what they need to succeed academically will contribute to greater health outcomes and a thriving economy. – Community Leader

Lack of finances, lack of resources, language barriers, transportation, lack of social work providers. – Health Provider

We have families that work at employment options that do not pay a living wage, our community lacks affordable housing. We also are seeing an increased number of families joining our community that are undocumented with very limited resources that experience discrimination and at times we do not provide a welcoming environment. Families within our community are also experiencing high levels of mental health challenges. – Community Leader

Correlated relationship of health and income, education, environment, and race. – Community Leader

Poverty! Substance abuse and access to health care. – Community Leader

Low-income folks do not always know how to connect with services. Financial resources are always an issue for most of us. Housing for low-income people is difficult to find, hard to qualify for help. Jobs for people with mental struggles that accommodate for the restrictive nature of their illness. So many children are living in very challenging environments with families that struggle daily for security of food, housing, financial needs. – Community Leader

Everyone does not start out life at the same place. People born with privilege will live longer and have more health and money than those born into poverty (see The Opportunity Atlas). Addresses and ZIP codes are good indicators of wealth/income because of SDOH. Medical providers and community organizations need more training on this. People are often blamed for not excelling at life, but often, they were not set up to succeed. – Community Leader

Homelessness

The United Way and its team of agency directors present data and speak to this problem consistently. Homelessness is on an apparent rise. Affordable housing chases lower income folks to other communities; perceived lack of affluence and educational supports chases the other end to Carmel (where housing costs are similar). Amazing people are trying to address questions of equity, but culture is a slow-turning ship. – Community Leader

Look at the people walking around overweight and people living on the streets that are homeless. – Health Provider

Homelessness is a major problem. – Physician

Significant homeless and vulnerable populations exist. – Community Leader

> Families that are unhoused or multiple families living together, lack of low-income housing, lack of assistance to help mitigate bed bug infestations when families can't afford it. When on a fixed income, health care is not often prioritized unless there is an illness. No low-cost options for dental care in this community. – Health Provider
>
> The homeless population seems to have increased. COVID caused many kids to lag behind – even those with access to resources did not learn well during those years. Food insecurity is on the rise, incomes are not keeping up with inflation and housing prices. Open discrimination has been on the rise since 2016. – Community Leader

Access to Care/Services

> Lack of resources and connections to existing resources, especially for families in poverty. – Community Leader
>
> We lack competition of resources in the community. – Community Leader
>
> A lot of access issues, cost barriers, and transportation. – Community Leader
>
> Environmental issues, transportation, food deserts, folks don't know where to get free services. – Community Leader

Affordable Care/Services

> Cost of care is a barrier. – Community Leader
>
> The cost of health care in this county far exceeds the ability of many people to afford it. The wages in this community are not keeping up with the cost of health care, housing, food, etc. We are a high-tax community, which further complicates residents' ability to afford high-quality health care. – Community Leader

Awareness/Education

> More and more people are reaching adulthood without knowledge of healthy habits. Income and education are major determinants. – Community Leader
>
> I don't think our community has a lot of knowledge surrounding social determinants of health and understanding how crucial they can be. – Community Leader

Denial/Stigma

> Stigma, lack of education for parents, grandparents, those raising children. Lack of knowing about available resources. Expansion of resources – housing, for example. – Social Services Provider
>
> Stigma against mental health patients. – Social Services Provider

Transportation

> Lack of transportation and lack of good housing are factors for many people in our community. Lack of affordable child care is also a major barrier. – Physician
>
> Social drivers of health like lack of transportation, poverty, low health literacy, etc. are all known to influence health. There are studies that have repeatedly shown this. – Physician

Built Environment

> The neighborhood where you live, where you work, who you hang out with, where you get your news, a person's inherent ability to process information – we are not all created equal in terms of our capacity to make mostly better decisions. Transportation. Always, the access provided at higher socioeconomic levels is not available to much of the population. Not sure how much institutional discrimination continues, but it is an issue that constantly needs to be continuously monitored and improved. – Community Leader

Social Norms/Community Attitude

> Social determinants of health in Columbus – Social norms that don't support a healthy lifestyle, lack of family support, lack of healthy options for food, lack of well-being prioritization in comparison to basic needs, need for more health literacy/education, low wages in some sectors not keeping up with inflation, high housing prices due to large employers, Indiana has a lack of diversity, and social norms do not support DEI. – Health Provider

Co-Occurrences

> Most health issues that individuals face are created or aggravated by these social determinants. Working to impact the social determinants will make addressing the health issues more successful. – Health Provider

Incidence/Prevalence

> I pay close attention to surveys and data collections such as this. I know there is a lot of conversation and work being done around these determinants, but there is always a new barrier, and it is difficult to move the needle sometimes. – Community Leader

Access to Affordable Healthy Food

> They are affecting every community with the cost of healthy food and rising housing costs. – Health Provider

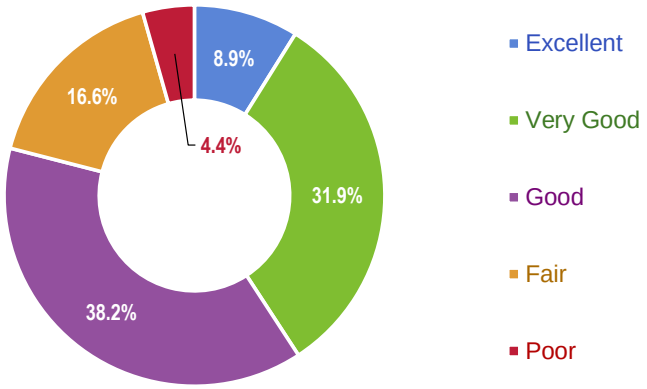
HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is excellent, very good, good, fair, or poor?"

Most Columbus Regional Health Service Area residents rate their overall health favorably (responding "excellent," "very good," or "good").

Self-Reported Health Status
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

However, 21.0% of Columbus Regional Health Service Area adults believe that their overall health is "fair" or "poor."

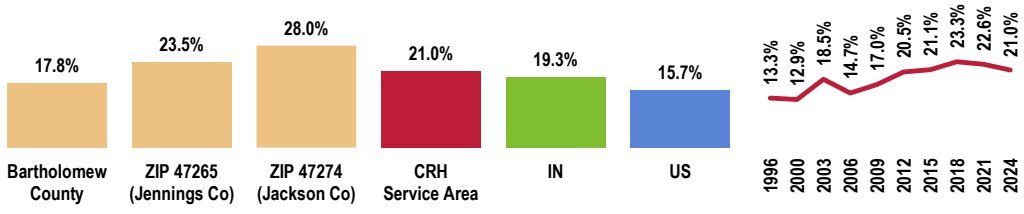
BENCHMARK ► Worse than found nationally.

TREND ► Similar to findings over the past decade, but higher than prior findings.

DISPARITY ► Lowest in Batholomew County. More often reported among male respondents, residents age 40+, and those with lower incomes.

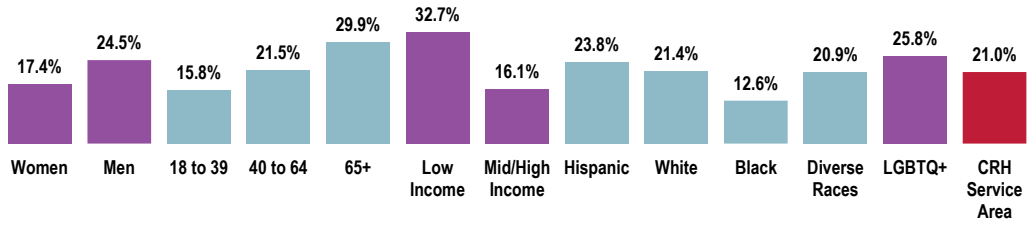
Experience "Fair" or "Poor" Overall Health

CRH Service Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Experience “Fair” or “Poor” Overall Health
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

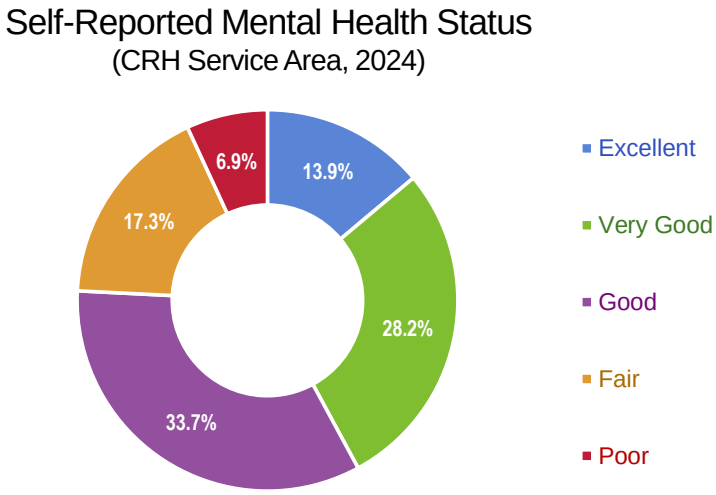
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

"Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is excellent, very good, good, fair, or poor?"

Most Columbus Regional Health Service Area adults rate their overall mental health favorably ("excellent," "very good," or "good").



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: • Asked of all respondents.

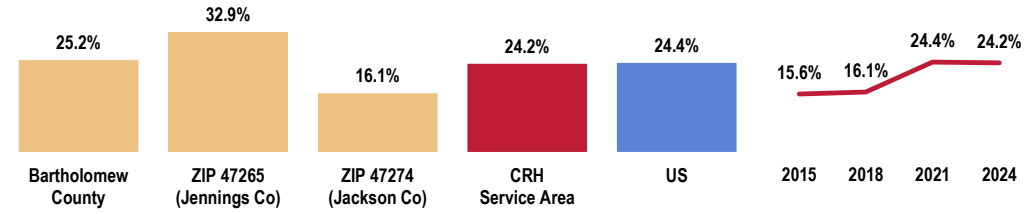
However, 24.2% believe that their overall mental health is "fair" or "poor."

TREND ► Represents a significant increase over time.

DISPARITY ► Lowest in Jackson County ZIP Code 47274.

Experience “Fair” or “Poor” Mental Health

CRH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression

Diagnosed Depression

See also *Child Depression & Anxiety* in the Children’s Mental Health section of this report.

A total of 36.8% of Columbus Regional Health Service Area adults have been diagnosed by a physician or other health professional as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

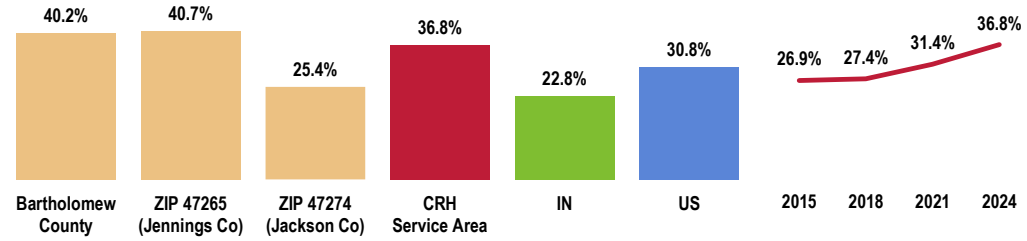
BENCHMARK ► Higher than found statewide and nationally.

TREND ► Trending significantly higher over time.

DISPARITY ► Lowest in Jackson County ZIP Code 47274.

Have Been Diagnosed With a Depressive Disorder

CRH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

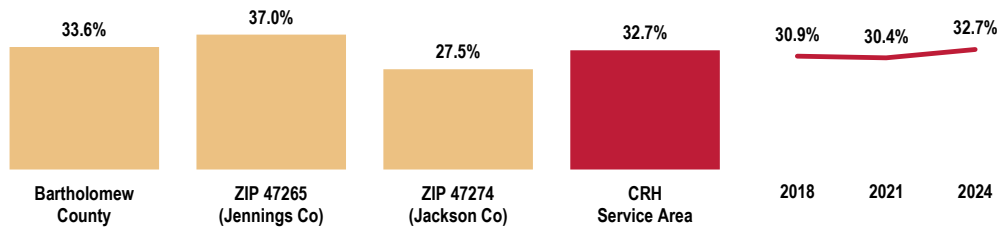
Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Depression

A total of 32.7% of Columbus Regional Health Service Area adults have had two weeks in their lives when they felt sad or depressed on most days.

Had Symptoms of Depression in the Past Year

CRH Service Area

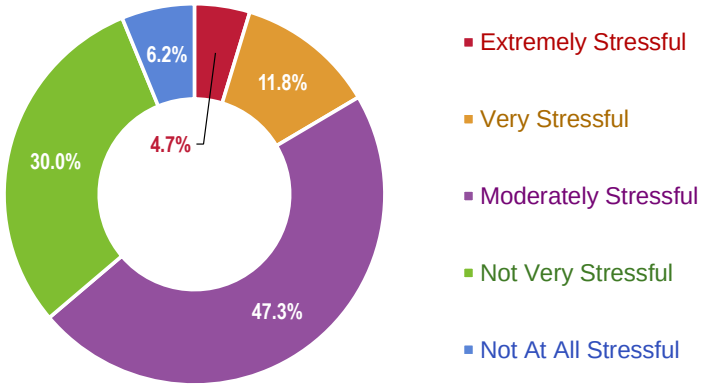


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 323]
Notes: ● Asked of all respondents.
● Reflects respondents reporting any period of two or more weeks in the past year when they felt sad or depressed most days.

Stress

Most surveyed adults characterize most days as no more than "moderately" stressful.

Perceived Level of Stress On a Typical Day
(CRH Service Area, 2024)



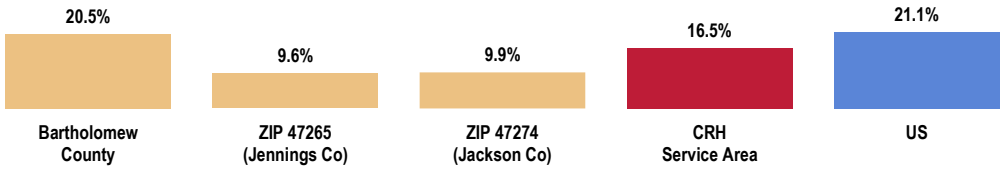
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

In contrast, 16.5% of Columbus Regional Health Service Area adults feel that most days for them are "very" or "extremely" stressful.

BENCHMARK ► Lower than the US percentage.

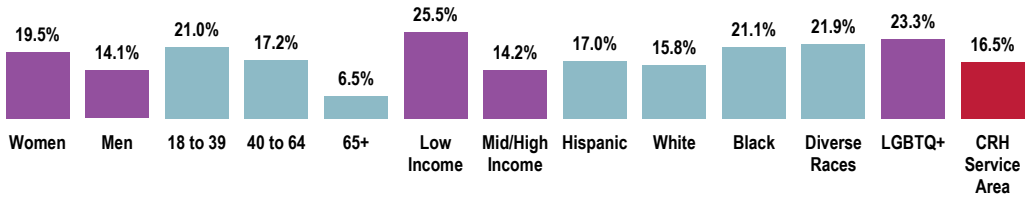
DISPARITY ► Highest in Bartholomew County. More often reported among women, adults younger than 65, and those with lower incomes.

Perceive Most Days As "Extremely" or "Very" Stressful



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Most Days as "Extremely" or "Very" Stressful
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Suicide

Suicide Deaths

Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.

In the Columbus Regional Health Service Area, there were 17.5 suicides per 100,000 population (2018-2020 annual average age-adjusted rate).

BENCHMARK ► Higher than the national rate. Fails to satisfy the Healthy People 2030 objective.

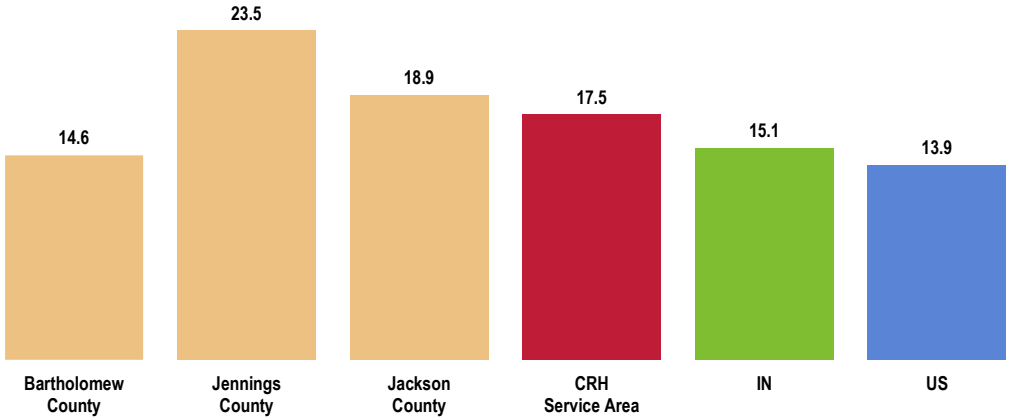
TREND ► Despite recent decreases, considerably higher than reported a decade ago.

DISPARITY ► Highest in Jennings County.

Suicide: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



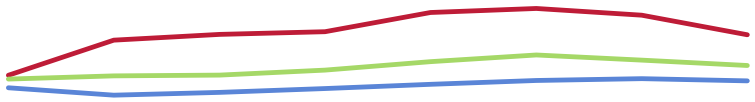
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower

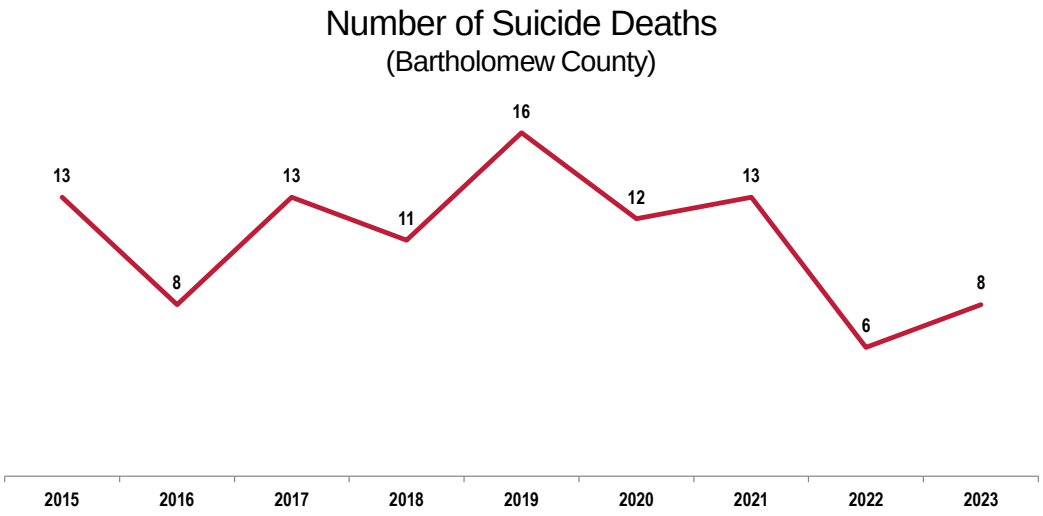


	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	14.3	17.1	17.5	17.7	19.2	19.6	19.0	17.5
IN	14.0	14.3	14.3	14.7	15.4	15.9	15.5	15.1
US	13.3	12.7	13.0	13.3	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Suicide counts for Bartholomew County between 2015 and 2023 are shown below.



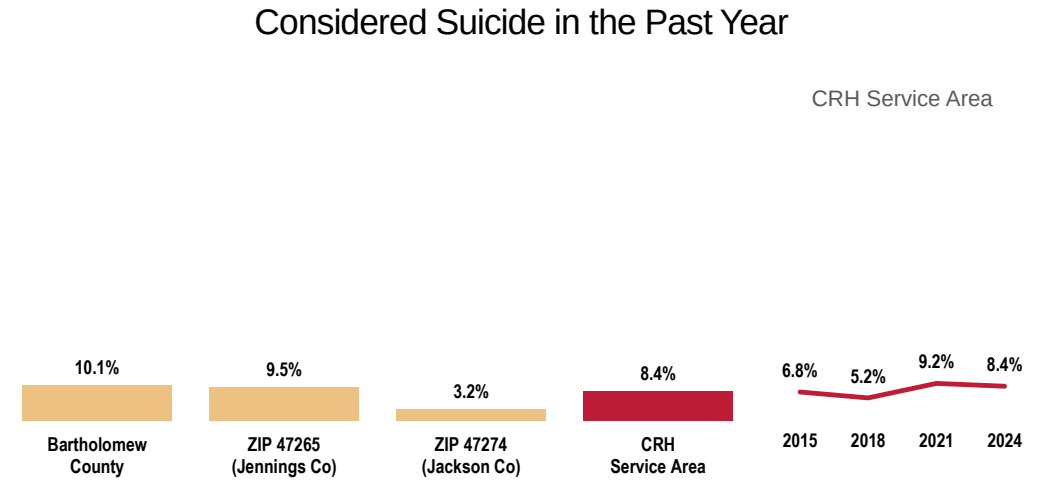
Sources: ● Source: Bartholomew County Coroner's Office https://bartholomew.in.gov/county-coroner.html#annual-report

Suicide Ideation

All survey respondents were informed they could talk to a trained counselor on the National Suicide Prevention Lifeline by calling or texting 988.

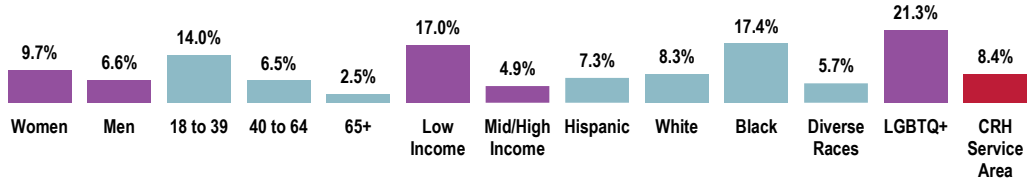
A total of 8.4% of surveyed adults report a time in the past year when they thought about taking their own lives.

DISPARITY ► Lowest in Jackson County ZIP Code 47274. More often reported among adults younger than 65, lower-income residents, and LGBTQ+ respondents. (Despite the variation shown, there is no statistically significant difference by race/ethnicity).



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 324]
Notes: ● Asked of all respondents.

Considered Suicide in the Past Year
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 324]
Notes: • Asked of all respondents.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Mental Health Treatment

Mental Health Providers

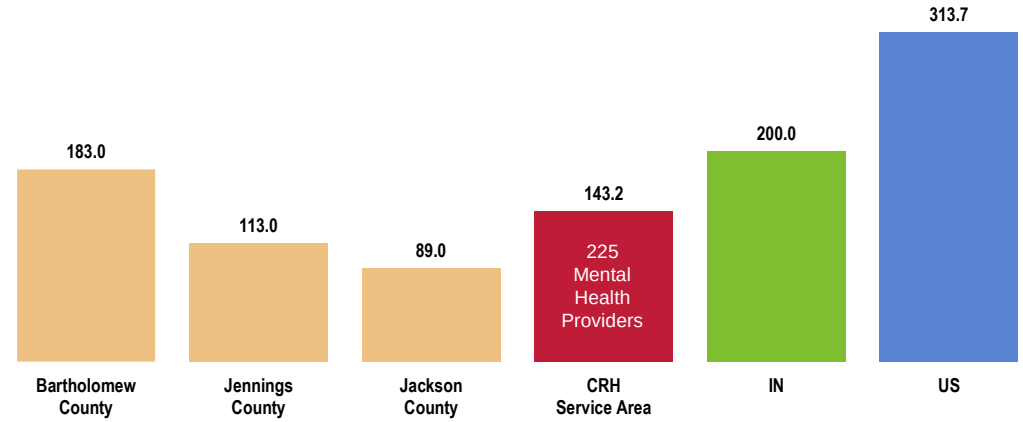
Note that this indicator only reflects providers practicing in the Columbus Regional Health Service Area and residents in the Columbus Regional Health Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

In the Columbus Regional Health Service Area in 2023, there were 143.2 mental health providers (including psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) for every 100,000 population.

BENCHMARK ► Less favorable than found across Indiana and the US.

DISPARITY ► Lower in Jennings and Jackson counties.

Number of Mental Health Providers per 100,000 Population
(2023)



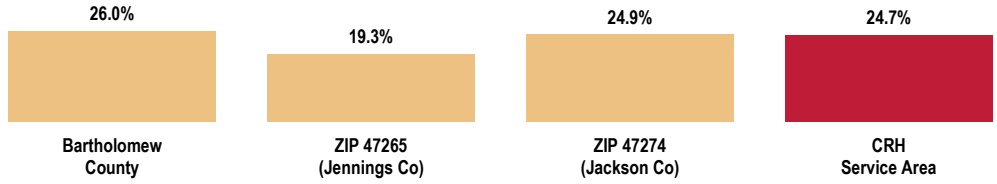
Sources: • Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).
Notes: • This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

Seeking Professional Help

Nearly one-fourth (24.7%) of service area adults report they have sought professional help for a mental or emotional problem within the past year.

Have Sought Professional Help for a Mental or Emotional Problem in the Past Year

Among respondents ever diagnosed with a depressive disorder, 50.0% have sought professional help in the past year.



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 325]
Notes: • Asked of all respondents.

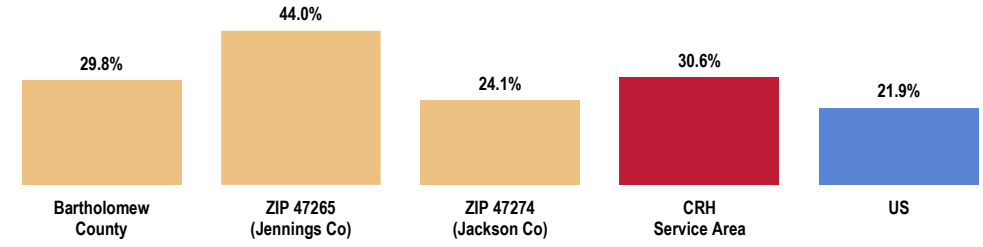
Currently Receiving Treatment

A total of 30.6% of area adults are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

BENCHMARK ► Higher than the national percentage.

DISPARITY ► Highest in Jennings County ZIP Code 47265.

Currently Receiving Mental Health Treatment



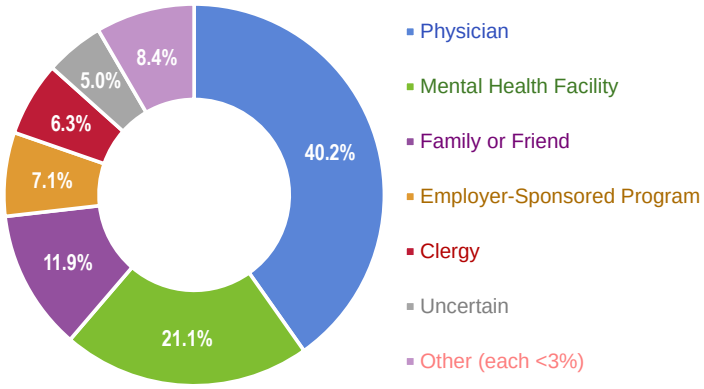
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 81]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

Access to Mental Health Services

Anticipated Site for Services

Asked where they would seek services for mental health if needed, the largest share of respondents (40.2%) mentioned a physician, while 21.1% would go to a mental health facility for help.

Anticipated Site for Mental Health Services If Needed
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 327]
Notes: ● Asked of all respondents.

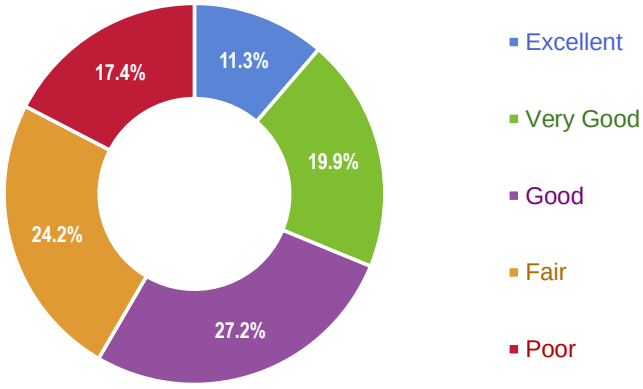
Perceptions of Accessibility

When asked to rate the ease of accessing local services for mental health, 41.6% of service area adults gave "fair" or "poor" responses.

TREND ► Trending worse over time.

DISPARITY ► More often reported among women, adults younger than 65, White residents, and especially LGBTQ+ respondents.

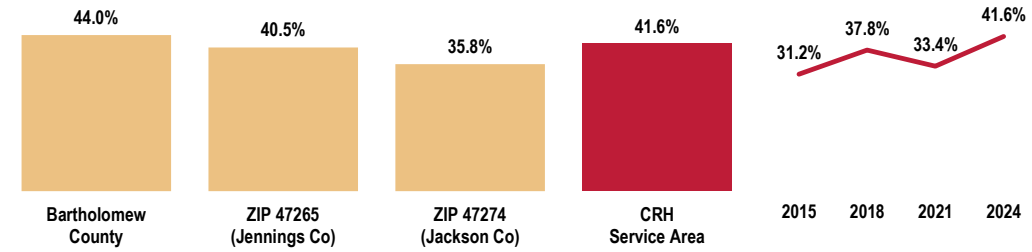
Perceived Ease of Obtaining Local Mental Health Services
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 322]
Notes: ● Asked of all respondents.

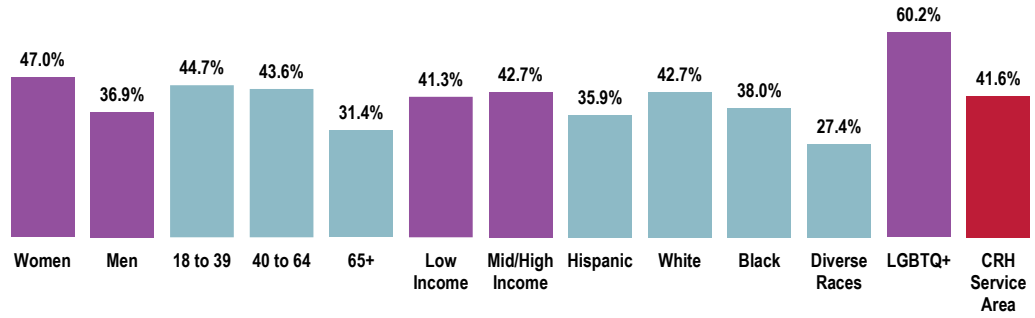
Ease of Obtaining Local Mental Health Services Is “Fair” or “Poor”

CRH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 322]
Notes: ● Asked of all respondents.

Ease of Obtaining Local Mental Health Services Is “Fair” or “Poor”
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 322]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

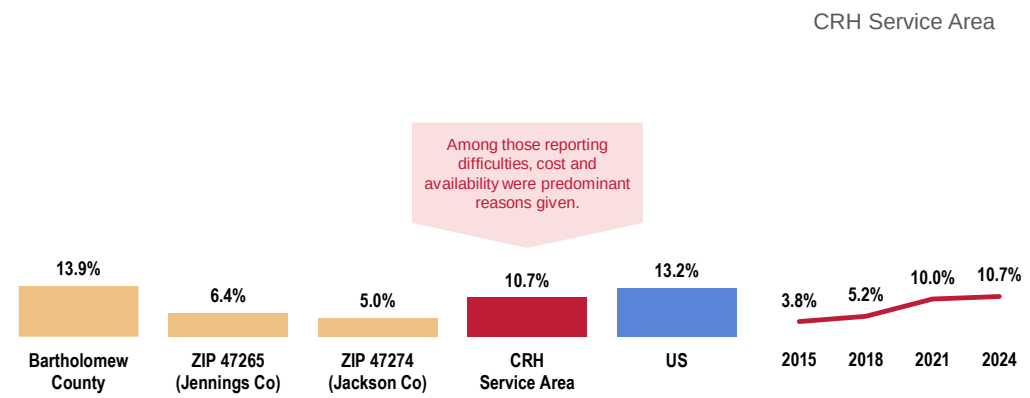
Difficulty Accessing Services

A total of 10.7% of Columbus Regional Health Service Area adults report a time in the past year when they needed mental health services but were not able to get them.

TREND ► Rising significantly higher over time.

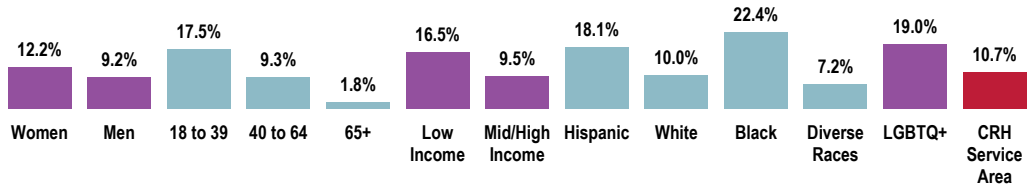
DISPARITY ► Highest in Bartholomew County. More often reported among adults younger than 65 (especially those age 18 to 39), lower-income residents, and LGBTQ+ respondents.

Unable to Get Mental Health Services When Needed in the Past Year



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 82, 326]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(CRH Service Area, 2024)



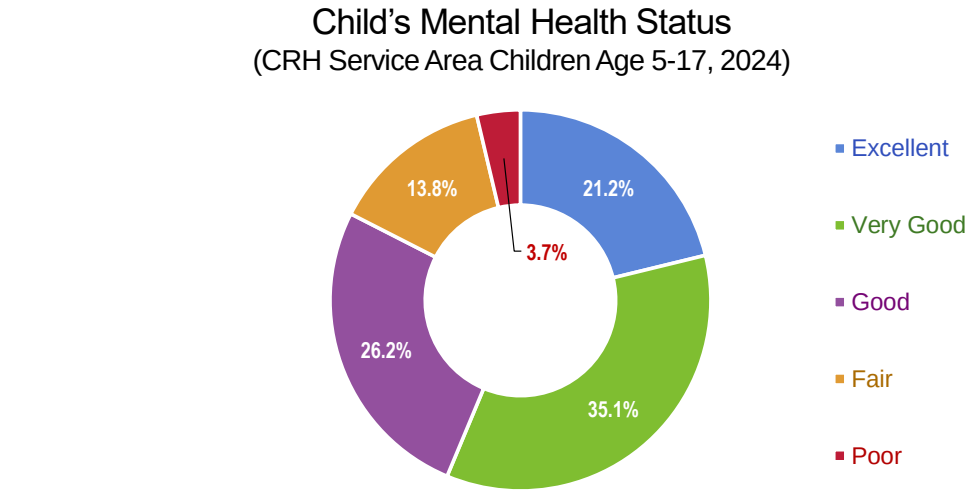
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Children's Mental Health

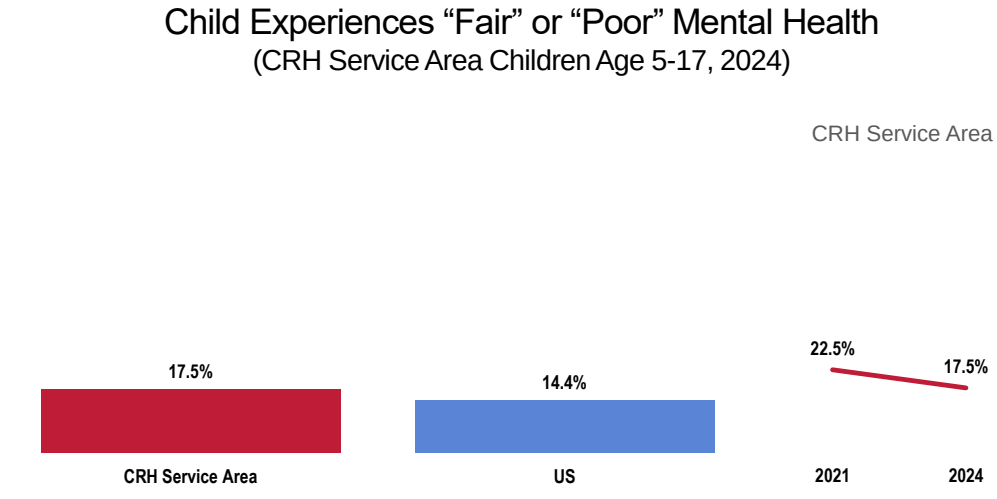
Children's Mental Health Status

More than one-half of parents of a child age 5 to 17 (56.3%) consider their child's mental health to be "excellent" or "very good."

In contrast, 17.5% of Columbus Regional Health Service Area parents feel their school-age child experiences "fair" or "poor" mental health.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 331]
Notes: ● Asked of all respondents with a child age 5-17 at home.



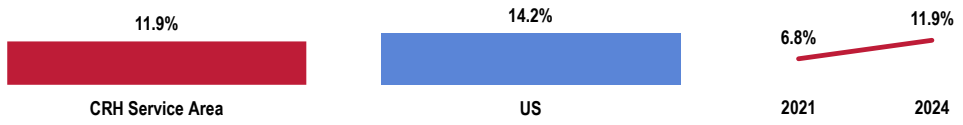
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 331]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with a child age 5-17 at home.

Child Depression & Anxiety

In the past year, 11.9% of parents indicate that their child (age 5 to 17) felt so sad or hopeless almost daily for two or more weeks that he/she stopped doing some usual activities (symptoms of depression).

Child Experienced Symptoms of Depression in the Past Year
(CRH Service Area Children Age 5-17, 2024)

CRH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 334]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with a child age 5-17 at home.
- Symptoms include feelings of sadness or hopelessness that caused a disruption in usual activities over a two-week period or longer.

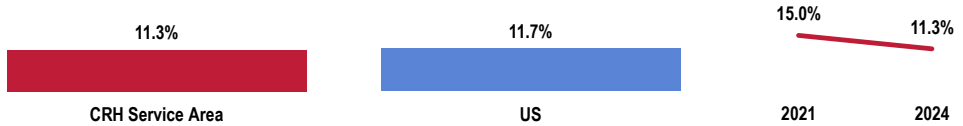
Diagnoses

A total of 11.3% of parents indicate that their child (age 5 to 17) has been diagnosed with <u>depression</u>.

DISPARITY ► More often reported among parents of adolescents.

Child Has Been Diagnosed With Depression
(CRH Service Area Children Age 5-17, 2024)

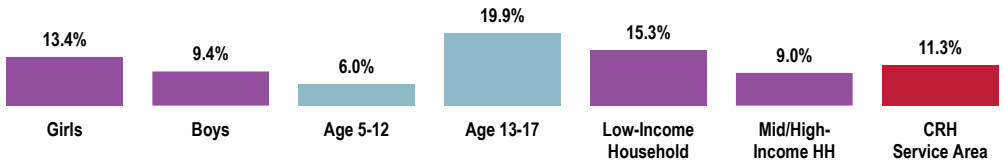
CRH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 336]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with a child age 5-17 at home.

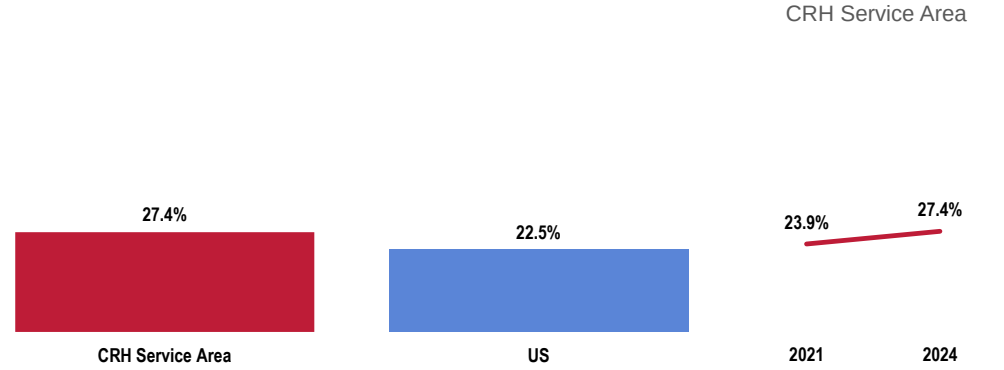
Child Has Been Diagnosed With Depression
(CRH Service Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 336]
Notes: ● Asked of all respondents with a child age 5-17 at home.

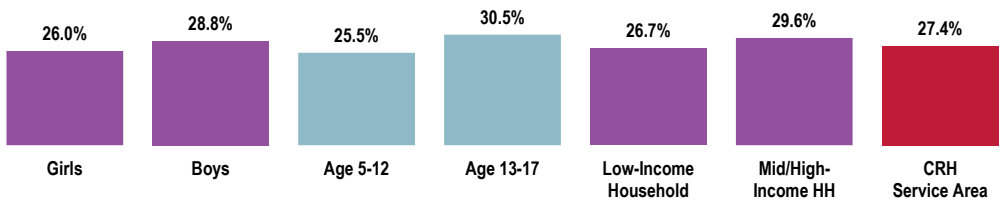
A total of 27.4% of parents indicate that their child (age 5 to 17) has been diagnosed with anxiety.

Child Has Been Diagnosed With Anxiety
(CRH Service Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 337]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with a child age 5-17 at home.

Child Has Been Diagnosed With Anxiety
(CRH Service Area Children Age 5-17, 2024)



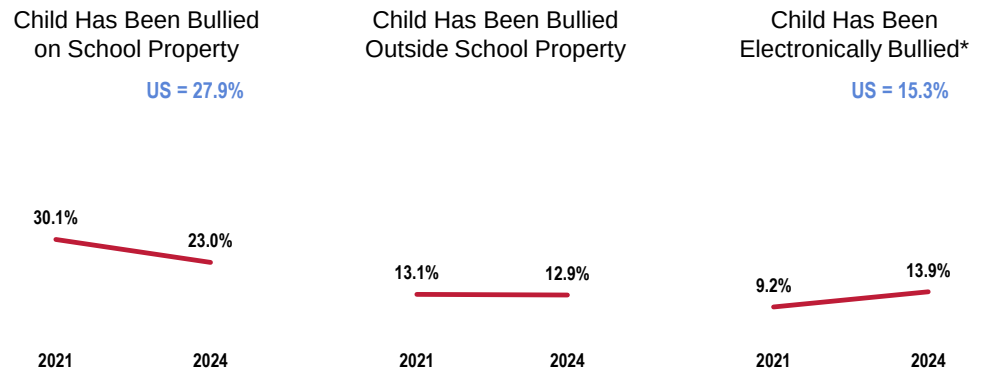
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 337]
Notes: ● Asked of all respondents with a child age 5-17 at home.

Bullying

Bullying is when one or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when two students of about the same strength or power argue, fight, or tease each other in a friendly way.

In the past year, 23.0% of parents with school-age children report that their child was bullied on school property, while 12.9% were bullied outside school property, and 13.9% were electronically bullied (through social media sites, email, chat rooms, instant messaging, websites, or texting).

Incidence of Bullying in the Past Year
(CRH Service Area Children Age 5-17, 2024)



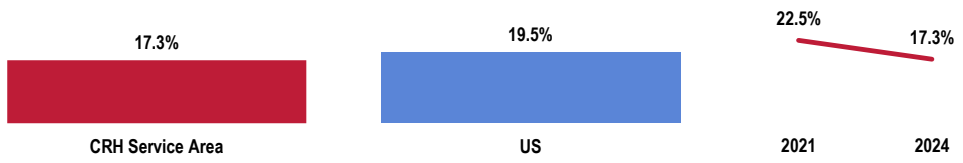
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 338-340]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with a child age 5-17 at home.
● * In this case, electronic bullying includes bullying through social media sites, email, chat rooms, instant messaging, websites, or texting. Note that social media was not included in the survey question in 2021.

Treatment for Children's Mental Health

In all, 17.3% of service area children age 5 to 17 received some kind of treatment or counseling for mental health in the past year (separately, 19.3% were reported to have had a need of mental health services in the past year).

Child Received Professional Treatment/Counseling in the Past Year
(CRH Service Area Children Age 5-17, 2024)

Note that 19.3% of area children age 5-17 have needed mental health services in the past year.

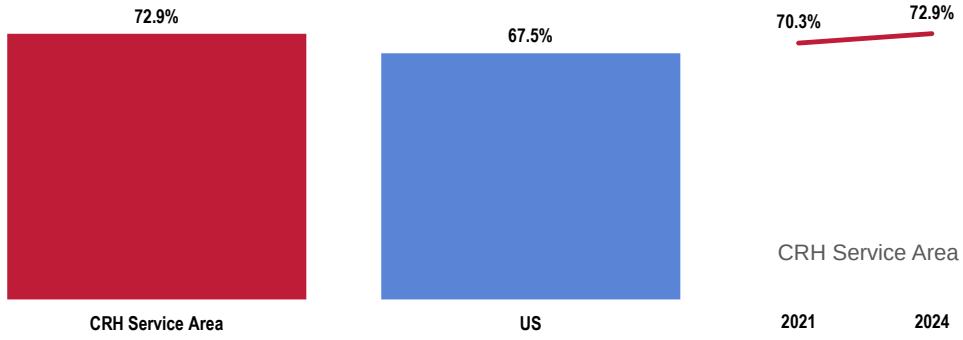


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 332-333]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with a child age 5-17 at home.

Awareness of Resources

Among Columbus Regional Health Service area respondents with children under the age of 18 in the household, 72.9% are aware of local resources for children's mental health.

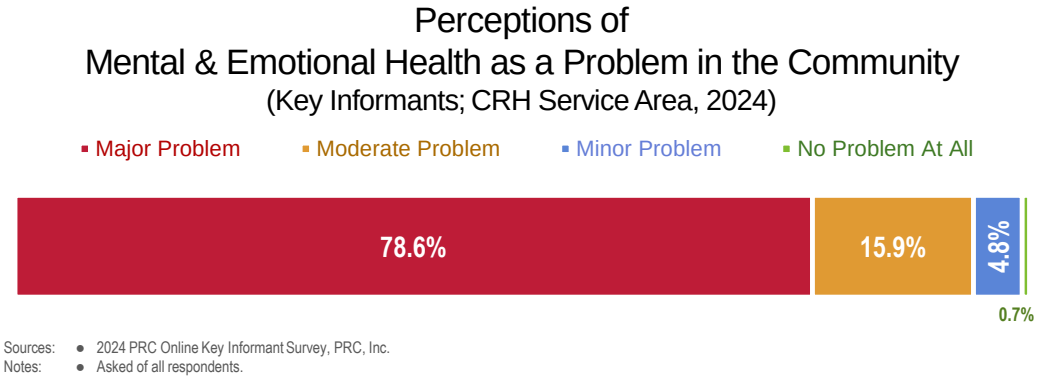
Awareness of Local Resources for Children's Mental Health
(CRH Service Area Parents of Children Age 0-17, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 341]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with a child age 0-17 at home.

Key Informant Input: Mental Health

A high percentage of key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Residents with mental health illness often have barriers to accessing care. – Community Leader

Access, but also the person wanting help, which is not an issue with the facility. Maybe better follow-up and easier access would help. – Health Provider

Access to mental health providers, ability to afford treatment and medications. – Public Health Representative

Access to mental health services. – Community Leader

Access to care. Discovering and addressing root causes. Cost of mental health care. Most insurance companies do not cover mental health or require deductibles to be met before covering therapy. For those with copays, mental health care is usually classified as a specialty service, which requires a higher copay. – Community Leader

Access to care, taking medications as prescribed. – Community Leader

Limited access to resources, providers not on the same page, and the stigma around asking for help. – Community Leader

Major issues not being addressed in the community with proper facilities. – Community Leader

Connecting people to resources, making resources accessible, helping people understand the questions to ask themselves to know which direction to go. – Community Leader

Access to and paying for services. – Community Leader

Access to services due to lack of capacity. – Community Leader

Timely access to mental health treatment is a concern. There are long wait lists, and the cost is also a concern for low-income individuals. – Community Leader

Very limited services available for mental health issues. – Community Leader

Access to counseling and doctors who are appropriately trained to treat mental health disorders. – Physician

Access to care and the cost. – Social Services Provider

This project is in the works and being addressed, just not in the action phase yet, but the biggest is access and availability. – Health Provider

Access to care – there isn't enough. – Community Leader

Lack of access. People in crisis often have to wait to see a provider. I experienced this with a coworker who was on suicide watch and couldn't see a professional for weeks. – Community Leader

Timely access to mental health services, particularly for youth. – Health Provider

Access to proper services for youth and teenagers in our community. Needs to be an emphasis on prevention. – Community Leader

Available access to licensed counselors. – Community Leader

Access to therapists. While this is improving and crisis services are now available, the needs continue to outpace the available resources. – Social Services Provider

Lack of access and barriers to care (for example, Centerstone requires an intake before a patient can see a prescriber to get medicine, and there is a long wait list to get in to see prescriber). Comorbid conditions (SUD, for example) often complicate adherence to treatment plan and follow-up. Social drivers of health like poverty, lack of access to transportation, low health literacy, as well as stigma also often impact patient's willingness or ability to seek care. – Physician

Lack of rubber on services, transitional housing. – Community Leader

Lack of good resources and lack of adequate insurance coverage. Lack of family and pediatric resources. – Physician

Resources to refer people. – Social Services Provider

Getting the proper care they need and the follow-up. Access to mental health counseling I believe is an issue. – Community Leader

Lack of access to mental health resources, lack of representation, such as BIPOC and bilingual staff. Affordability and knowledge of where to go and when. – Health Provider

Timely access to comprehensive mental health services; housing for those that need support; availability of residential mental health treatment like is available for SUD; stigma of mental illness. – Community Leader

Long wait lists to get into mental health facilities. – Physician

Connecting mental health sufferers with appropriate support and services. – Community Leader

Lack of resources, like psychiatry and therapists. Many of these folks lack professional and personal support systems that force them to take medications they desperately need. – Community Leader

The biggest challenges are access to mental health care, especially for our youth, and the stigma surrounding mental health. We don't have enough providers, and many in our community don't know where to go to get care or are hesitant to do so in fear of being stigmatized as "mentally ill." – Health Provider

The biggest problem that I see is availability of adequate facilities, staffing issues, and lack of long-term care solutions for the chronically mentally ill. – Community Leader

Access to mental health professionals or appropriate individualized mental health plans. – Community Leader

Lack of outpatient services. – Community Leader

Lack of early childhood mental health services. A lot of places will not serve children under the age of 5. Not being able to afford services. – Social Services Provider

Little to no access to mental health providers. Lack of a therapeutic environment for people who need inpatient care. – Health Provider

Of course, everything goes back to the lack of a national universal health care scheme, so that is the biggest challenge in the absence of resources. The lack of funding, inadequate facilities, inadequate availability of mental health professionals (in a period of constrained labor) rise to the top of the list. We also have to recognize the individual in this as well, and the stigma associated with admitting/acknowledging personal mental health issues. – Community Leader

Insufficient number of mental health services. – Community Leader

Access to counseling, therapy, physicians, and other behavioral health professionals. – Health Provider

Lack of resources and connections to those resources, especially from families in poverty. – Community Leader

Being able to access services in a timely manner. Lack of choices in providers, especially with medication needs. Lack of free or low-cost services. Lack of choices for children in need of counseling services. – Social Services Provider

Access, especially for long-term inpatient and outpatient treatment, stigma, awareness, and available providers. – Health Provider

Access to care and support, especially for children, youth, and their caregivers. Safe, supported housing for those with serious mental illness. Chronically homeless. – Health Provider

Access and, more importantly, coordination and connecting to physical health issues. – Community Leader

Access to care, care coordination, and continuum of care (limited access to the records and history). We need many more mental health providers to meet the needs of the community. You cannot get scheduled for a mental health provider or a neuropsychic eval in less than three months. – Health Provider

Access to mental health practitioners and increased mental health concerns within the community. – Community Leader

Outpatient doctors, psychiatrist availability, easy psychotherapy access, psychologist availability, psychiatry social worker availability, hybrid therapy collaboration and coordination, social determinants of health need assessment, and resource provision. – Physician

Being able to get in to see a provider in a reasonable time. From what I have been told, it takes a long time to get in to see someone. – Community Leader

Lack of resources. – Health Provider

Just the availability of services covered by insurance and the comfort to reach out to those services without bias or judgement. – Social Services Provider

Access of services and after-care. – Social Services Provider

Lack of capacity. – Community Leader

Access to care. – Community Leader

Access to mental health providers. Access to rehabilitation. Stigma. – Community Leader

Access. – Community Leader

Timely access to care. – Community Leader

Access to care. – Health Provider

Access to services, lack of insurance, money, language barriers, and stigma. – Social Services Provider

Lack of Providers

Lack of mental health providers and lack of support and awareness to deal with emerging problems, particularly in children and youth. – Health Provider

Primary care providers do the majority of mental health care in our community. There aren't enough therapists, and without a simple central database, they are difficult to keep track of for selection or recommendation as someone who works in health care. Clinics are not given updated information on therapy options in the community. This is literally a DAILY issue in primary care. When someone has severe mental illness or has complicated medication issues, our only options are to refer to nurse practitioners (who do great work, but many are new and have knowledge gaps) or to Centerstone. We need psychiatrists. Dr. Spurgeon has a great care model – help people find the right medications for them and transfer back to PCP when appropriate. This is best for access for her, and most patients prefer seeing their PCP once stable. – Physician

Lack of providers. – Health Provider

Lack of mental health providers and counselors in our area. The long wait lists to get seen. – Health Provider

Accessing care in person. Bartholomew County is lacking providers for eating disorders and pediatrics. Access to culturally-specific care, not just translating, but providers who understand the culture. – Health Provider

Lack of mental health providers. Lack of beds at surrounding facilities to transport patients to, lack of outpatient access, and lack of resources for children. – Health Provider

Not enough certified health professionals. – Social Services Provider

Lack of providers who will treat people with SPMI like schizophrenia, lack of resources for caregivers of SPMI. Lack of providers who will treat prescribe stimulants for people (like me) with ADHD. Lack of providers of non-CBT based therapies. Lack of gerontology providers who will prescribe medication. Lack of testing for low-income adults who are likely autistic but can't get an affordable diagnosis. – Community Leader

The number of providers available and access to the services. – Community Leader

Not enough professionals to help everyone who needs it. Finding the right provider, stigma around getting help, and parental support. – Community Leader

Affordable Care/Services

Access to affordable care and receiving that care in a timely manner. – Community Leader

Expense and cost, transportation, and scheduling. Lengthy wait times to be seen for an appointment. – Community Leader

The ability to access services that are affordable. Many times, insurance doesn't pay for services on an ongoing basis. Services are limited to a number of visits, or the out-of-pocket amounts are too great for people to afford. Also, the number of therapists and their case loads are too large, and finding someone to provide the services puts folks on a waitlist for services that may never come or come too late. – Social Services Provider

There is a significant lack of access to affordable resources for counseling and mental health interventions. Some of this could be informational, and some could be infrastructure. – Community Leader

Getting help and counseling from a certified professional is affordable. – Community Leader

Access to affordable care. – Community Leader

Denial/Stigma

Afraid to say anything for fear of being labeled as crazy. – Community Leader

Stigma to admit and address the problem. Lack of available and affordable mental health providers, such as therapists, counselors, etc. – Community Leader

The topic of mental health is stigmatized, making it difficult for many of us to talk about. However, ALL individuals are on a continuum of mental health from "outstanding" to "debilitating," and their location on that continuum may vary from moment to moment. Due to a variety of factors, both youth and adults are enduring more challenging mental health issues than before. The ability to recognize those challenges AND then identify resources (including providers) for assistance are issues for our community. – Community Leader

Stigma and inability to access services due to wait lists and lack of providers. – Community Leader

Alcohol/Drug Use

> Substance use disorder and mental health care (dual diagnosis) continue to be the number one health issue, especially for the seriously mentally ill and those who cannot self-navigate. Why do I feel this way? Because homelessness is a focal point in our community. It is estimated that a high percentage of persons with a serious mental health condition and those who also have a substance use disorder are highly represented among the homeless population. They cannot advocate for themselves. They are too sick. – Community Leader

> Addiction seems to be a stronghold that impacts the overall mental health crisis. When people seek substances for self-medication as opposed to mental health services that promote healthy choices, the issue of addiction increases. If mental health was more accessible and more relatable for their needs, it might be more of an option for intervention than substance use. – Social Services Provider

Awareness/Education

> They aren't able to get information or resources in their native language. The language barrier is the biggest challenge. – Health Provider

> Those needing help and/or family members do not know how to find mental health providers that can help them. – Public Health Representative

Diagnosis/Treatment

> Folks clearly in mental health distress not being admitted to the stress unit when it is appropriate. – Community Leader

> People who will listen and treat them with respect. – Community Leader

Disease Management

> The biggest challenge I see with the individuals I work with is them taking their medication consistently. I also struggle when individuals are severe on the mental health scale with what I can do and what options there are. – Community Leader

> People choose not to take medication or treatments. – Community Leader

Follow Up/Support

> Lack of follow-up and accountability after initial services are provided. Once an individual is initially treated, unless they have close family or friends, it is up to them to continue their medication, appointments, etc. – Community Leader

> Lack of support, lack of resources for those facing mental health issues. Stigma associated with mental health issues. Associated challenges that come with mental health issues, such as substance abuse, homelessness, violence, and suicide. – Health Provider

Screen Time/Technology

> Excessive screen usage and encouragement from a young age. This contributes significantly to our overall health and mental health and should be addressed, especially for our young children in the schools. – Community Leader

> I am concerned about youth mental health. I'm particularly worried about the impact of social media and electronic devices on our kids and the correlation to lower academic and life outcomes. – Community Leader

Access to Care for Medicare/Medicaid Patients

> Limited number of providers accepting Medicaid. Limited number of providers for youth. Limited number of providers in general in our community. Long wait times. – Health Provider

Co-Occurrences

> Many health issues and income issues link directly to this problem. People are sad and exhausted. – Community Leader

Due to COVID-19

> The mental health of the young people who were in school during the pandemic. – Community Leader

Funding

> Lack of funding to hire more mental health workers. It's hard to find mental health providers to work for and earn a competitive salary. Schools need more mental health support and counseling services. – Community Leader

Homelessness

> With the Stride Center in town, our homeless population has skyrocketed. We are seeing homeless from as far as Evansville coming to our community. Homeless camps are all over the city. With homelessness, we also see a rise in mental health concerns and issues. The lack of decent mental health care is astonishing. – Community Leader

Stress

> People are struggling with unprecedented amounts of stress and at the same time, there are almost no providers who have spots for therapy and/or medication management. Those with spots almost never take Medicaid. – Health Provider

Suicide Rates

> Suicidality, serious untreated mental health problems, such as severe depression, bipolar disorder, and schizophrenia, and the burden on the local health system's emergency department and primary care providers because of the lack of psychiatric care. – Physician

Income/Poverty

> Depression, poverty, homelessness, inflation, political divide, etc. is driving increases in depression. – Community Leader

Teen/Young Adult Usage

> Youth and adolescent mental health and addictions, intensive services. – Health Provider

Housing

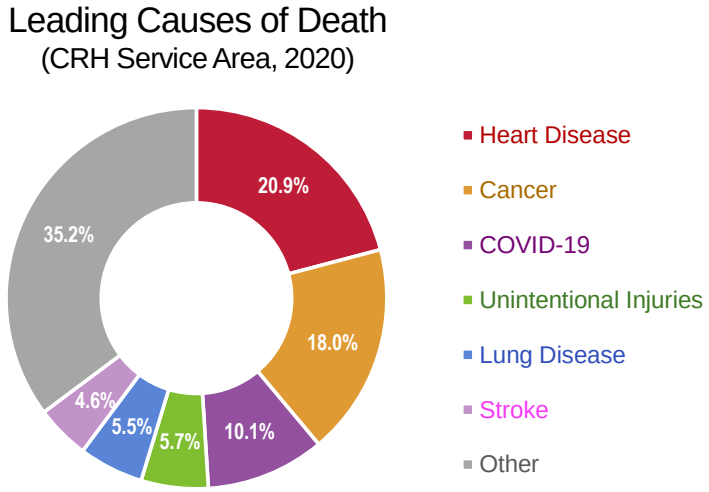
> Housing, finding qualified treatment specialists, poverty. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for nearly 4 in 10 deaths in the Columbus Regional Health Service Area in 2020.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: ● Lung disease includes deaths classified as chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Indiana and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

The following chart outlines 2018-2020 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Columbus Regional Health Service Area.

Leading causes of death are discussed in greater detail in subsequent sections of this report.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	CRH Service Area	Indiana	US	Healthy People 2030
Heart Disease	173.0	181.1	164.4	127.4*
Cancers (Malignant Neoplasms)	165.4	163.9	146.5	122.7
COVID-19 (Coronavirus Disease) [2020]	93.1	103.2	85.0	—
Unintentional Injuries	69.0	59.4	51.6	43.2
Lung Disease (Chronic Lower Respiratory Disease)	55.5	55.7	38.1	—
Stroke (Cerebrovascular Disease)	42.2	40.3	37.6	33.4
Falls [Age 65+]	37.5	45.6	67.1	63.4
Unintentional Drug-Induced Deaths	31.8	26.6	21.0	—
Alzheimer's Disease	22.5	33.1	30.9	—
Motor Vehicle Deaths	18.8	12.6	11.4	10.1
Suicide	17.5	15.1	13.9	12.8
Kidney Disease	17.4	17.4	12.8	—
Diabetes	16.4	26.9	22.6	—
Pneumonia/Influenza	15.9	12.7	13.4	—
Cirrhosis/Liver Disease	13.8	15.4	12.5	10.9
Alcohol-Induced Deaths	8.8	13.1	11.9	—
Homicide [2011-2020]	2.8	6.7	5.9	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

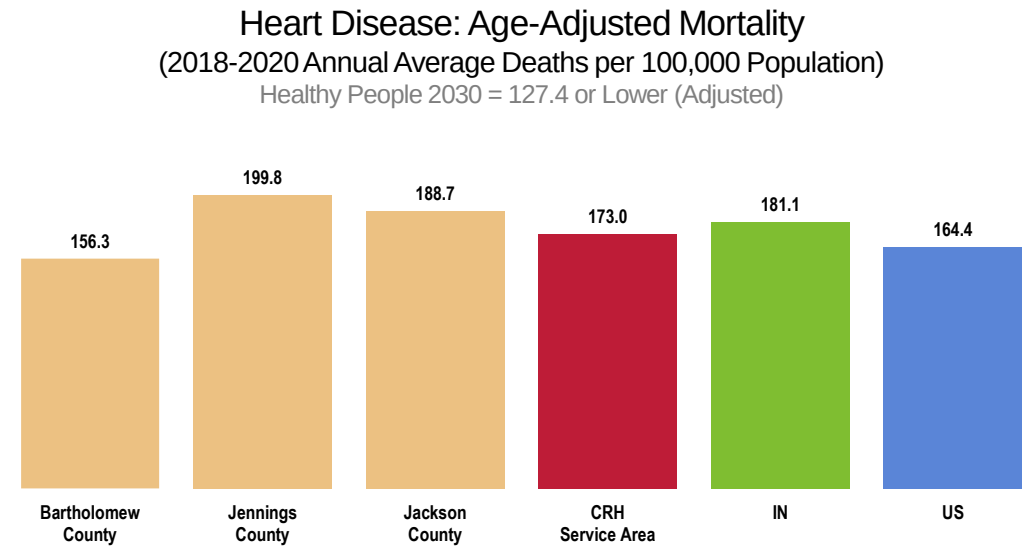
Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2018 and 2020, there was an annual average age-adjusted heart disease mortality rate of 173.0 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lowest in Bartholomew County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	178.6	183.1	184.3	188.6	186.0	176.4	169.0	173.0
IN	187.3	185.8	183.7	181.9	182.0	181.5	180.9	181.1
US	188.5	169.1	168.4	167.0	166.3	164.7	163.4	164.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Stroke Deaths

Between 2018 and 2020, there was an annual average age-adjusted stroke mortality rate of 42.2 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

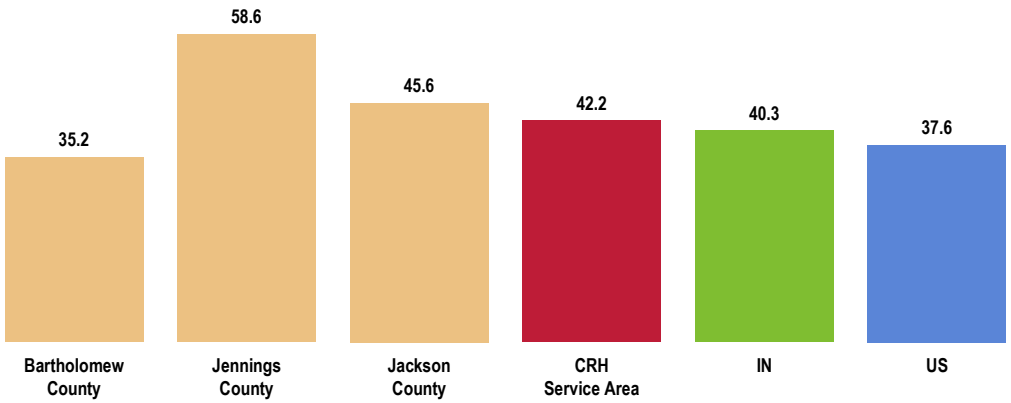
TREND ► Decreasing to the lowest level recorded within the service area in the past decade.

DISPARITY ► Highest in Jennings County.

Stroke: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



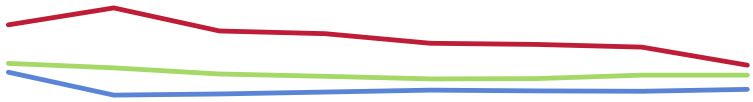
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	49.8	53.0	48.7	48.1	46.3	46.1	45.6	42.2
IN	42.5	41.7	40.5	40.1	39.6	39.7	40.3	40.3
US	40.9	36.5	36.8	37.1	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

A total of 47.2% of Columbus Regional Health Service Area adults have been told by a health professional at some point that their blood pressure was high.

BENCHMARK ► Worse than found across Indiana and the US. Fails to satisfy the Healthy People 2030 objective.

TREND ► Rising significantly higher over time.

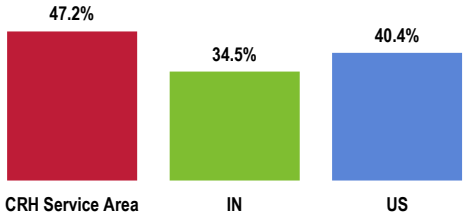
DISPARITY ► Highest in Jackson County ZIP Code 47274 (not shown).

A total of 34.8% of adults have been told by a health professional that their cholesterol level was high.

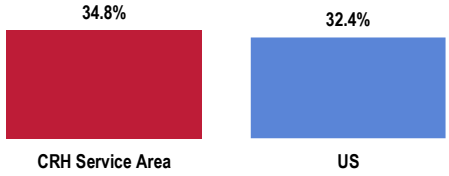
TREND ► Trending significantly higher over time.

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol

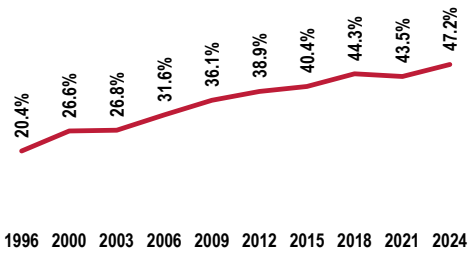


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

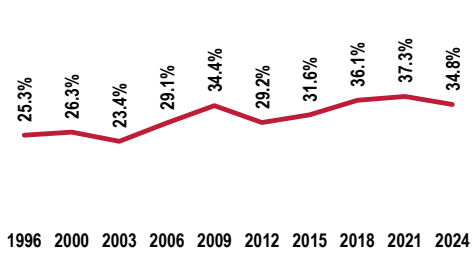
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure (CRH Service Area)

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol (CRH Service Area)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

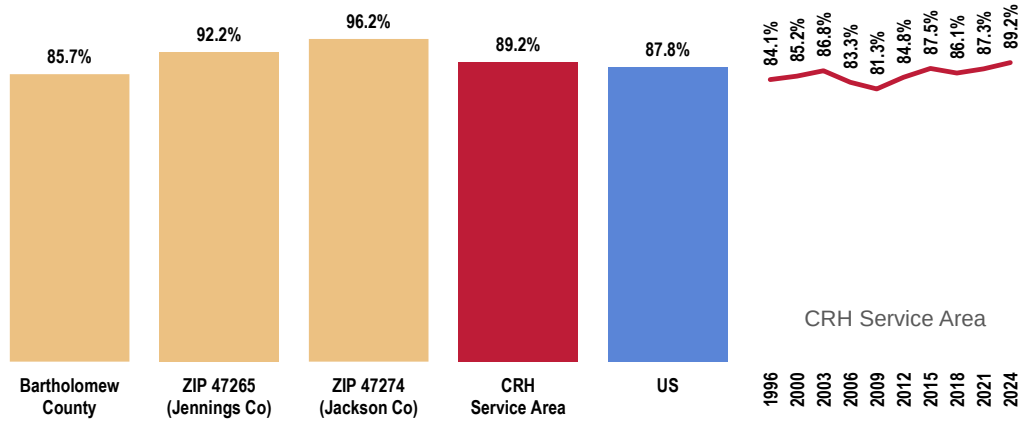
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

A total of 89.2% of Columbus Regional Health Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

TREND ► Marks a significant increase from the 1996 baseline.

DISPARITY ► Highest in Jackson County ZIP Code 47274. More often reported among residents age 40+, Hispanic respondents, and White respondents.

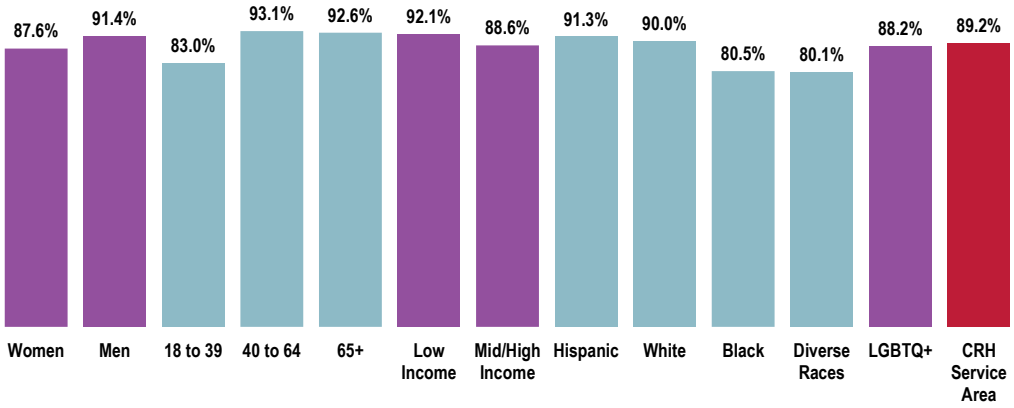
Exhibit One or More Cardiovascular Risks or Behaviors



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Exhibit One or More Cardiovascular Risks or Behaviors
(CRH Service Area, 2024)

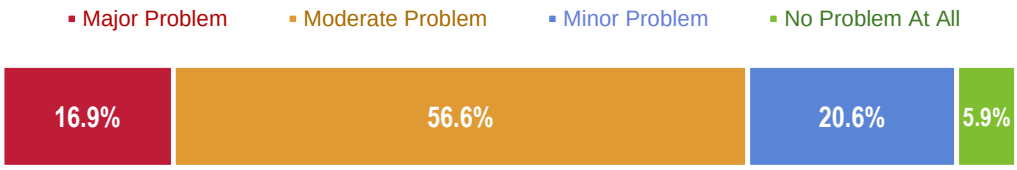


Sources: 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.

Perceptions of Heart Disease & Stroke as a Problem in the Community
(Key Informants; CRH Service Area, 2024)



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Obesity

> Obesity, smoking, substance abuse (such as meth and cocaine), lack of exercise, and the need for education regarding a heart-healthy diet. – Public Health Representative
>
> Obesity is a problem in our community, and as a result, this contributes to heart disease and stroke. – Health Provider
>
> Overweight, increased level of stress, lack of proper self-care, increased workload, finances. – Health Provider
>
> Obesity is a problem in our community, leading to a high risk for heart disease and stroke. – Community Leader
>
> Goes hand-in-hand with obesity. – Health Provider
>
> Obesity and an aging population. We are trending the wrong way. – Community Leader
>
> High rates of obesity and tobacco use. – Physician
>
> Obesity and high smoking rates. – Health Provider

Lifestyle

> Overall unhealthy lifestyles of diet and limited exercise. – Community Leader
>
> Due to diet and exercise issues, we have an increasing number of problems related to heart disease. – Community Leader
>
> Many people do not take care of their bodies to stay healthy. – Community Leader
>
> Poor eating habits, lack of access to fresh foods, drugs usage, and pool health management. Lack of physical activity. – Community Leader
>
> Due to the unhealthy eating habits, our ancestral and historical trauma, the environment, and stressors such as work, life, etc. of our community, we are at risk of higher chances of suffering from heart disease or stroke. – Health Provider

Incidence/Prevalence

> Major issues for a large population with more younger people being affected. – Community Leader
>
> Highest cause of death. – Community Leader

Awareness/Education

> Lack of knowledge about causes and prevention of heart disease. Lack of awareness of symptoms that could alert to an emerging problem. Focus on acute care vs. prevention. – Health Provider

Co-Occurrences

> These diseases are the etiology of many chronic and disabling situations. Practicing excellent health habits can help reduce unavoidable risks like genetics. Education, coaching, community support, and resources all encourage an individual to optimize their health. – Community Leader

Substance Use

> Excessive use of narcotics, tobacco, and alcohol. – Community Leader

Aging Population

> Aging population, obesity, smoking. – Social Services Provider

CANCER

ABOUT CANCER

The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

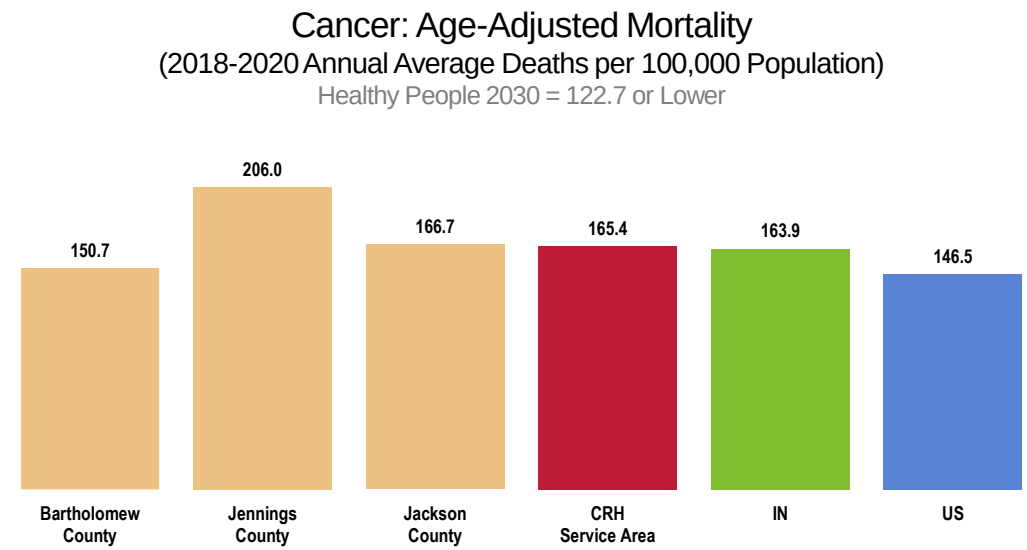
All Cancer Deaths

Between 2018 and 2020, there was an annual average age-adjusted cancer mortality rate of 165.4 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Decreasing significantly within the service area over time.

DISPARITY ► Highest in Jennings County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	196.7	197.0	192.7	181.8	174.9	171.2	171.8	165.4
IN	183.1	181.2	178.5	176.2	172.9	169.4	166.4	163.9
US	171.6	163.6	161.0	158.5	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the CRH Service Area.

Other leading sites include prostate cancer, colorectal cancer (both sexes), and female breast cancer.

BENCHMARK

Lung Cancer ► Higher than the national rate. Fails to satisfy the Healthy People 2030 objective.

Prostate Cancer ► Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Fails to satisfy the Healthy People 2030 objective.

Female Breast Cancer ► Lower than both state and national rates.

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

	CRH Service Area	Indiana	US	Healthy People 2030
ALL CANCERS	**165.4**	**163.9**	**146.5**	**122.7**
Lung Cancer	**46.9**	**42.7**	**33.4**	**25.1**
Prostate Cancer	**20.5**	**19.8**	**18.5**	**16.9**
Colorectal Cancer	**15.4**	**14.6**	**13.1**	**8.9**
Female Breast Cancer	**14.9**	**20.2**	**19.4**	**15.3**

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Prevalence of Cancer

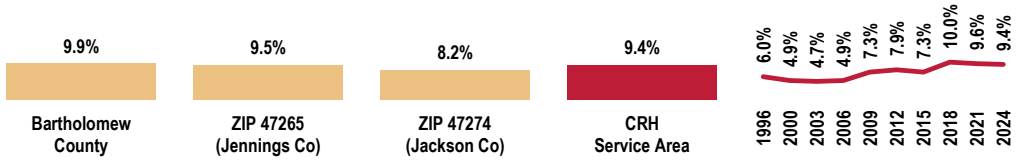
Skin Cancer

A total of 9.4% of surveyed Columbus Regional Health Service Area adults report having ever been diagnosed with skin cancer.

TREND ► Increasing since the mid-2000s.

Prevalence of Skin Cancer

CRH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

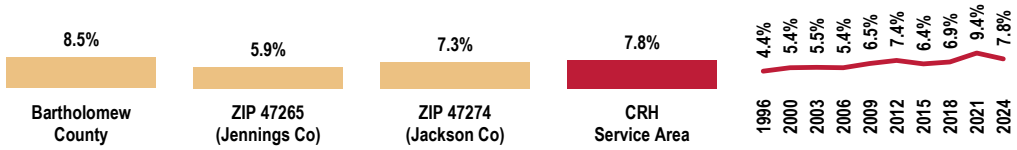
Other Cancers

A total of 7.8% of survey respondents have been diagnosed with some type of (non-skin) cancer.

TREND ► Rising significantly higher over time.

Prevalence of Cancer (Other Than Skin Cancer)

CRH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 301]
Notes: ● Asked of all respondents.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Women's Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures. Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Among women age 50 to 74, 86.2% have had a mammogram within the past 2 years.

BENCHMARK ► More favorable than found across the state and nation. Satisfies the Healthy People 2030 objective.

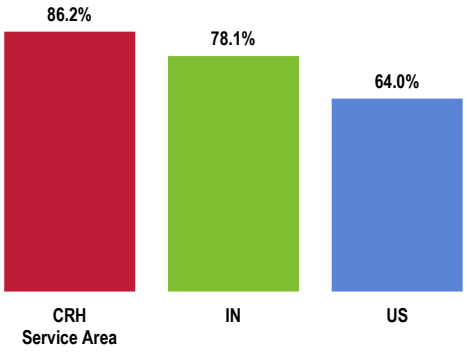
TREND ► Rising significantly to an all-time high within the service area since 2012.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every 3 years in women age 21 to 65.

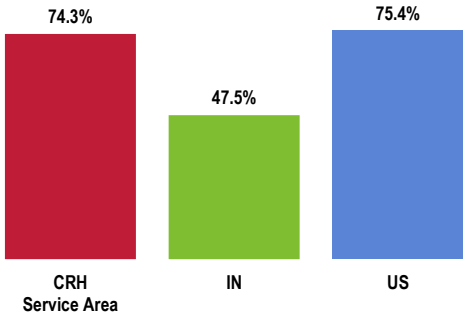
Among Columbus Regional Health Service Area women age 21 to 65, 74.3% have had appropriate cervical cancer screening.

BENCHMARK ► Much more favorable than found across Indiana but fails to satisfy the Healthy People 2030 objective.

Breast Cancer Screening
(Women Age 50-74)
Healthy People 2030 = 80.5% or Higher



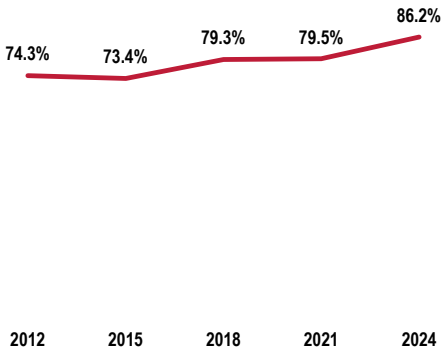
Cervical Cancer Screening
(Women Age 21-65)
Healthy People 2030 = 84.3% or Higher



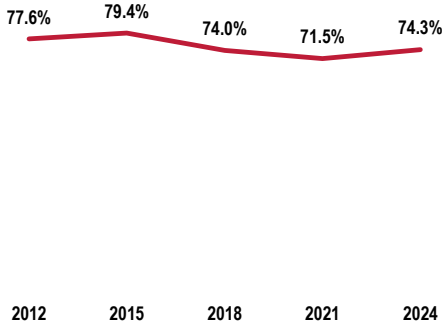
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-102]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.

Breast Cancer Screening
(Women Age 50-74)
Healthy People 2030 = 80.5% or Higher



Cervical Cancer Screening
(Women Age 21-65)
Healthy People 2030 = 84.3% or Higher

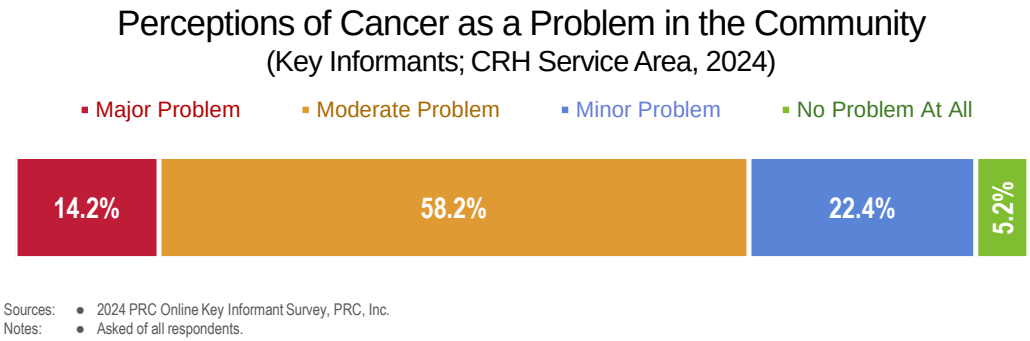


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-102]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

I know a lot of people who either have or have had cancer. – Community Leader

It seems that family and friends are being diagnosed more often. – Social Services Provider

There are so many who are diagnosed. People seem to have a challenge deciding if they go to Indianapolis or stay in Columbus to receive treatment. – Community Leader

It seems 75% of my requests are to people either with or have family members that have cancer. – Community Leader

It seems everyone knows someone struggling with cancer, and there are many people that are receiving appropriate screening to know cancer is present. – Community Leader

Seems to be increasing all around, and not just here. Can our local system handle the increase is another concern. – Community Leader

People I know are treated for an identified cancer and become cancer-free, and then discover that the cancer has reappeared, calling for repeated or expanded treatment. – Community Leader

There is a high prevalence of cancer in our community. – Community Leader

There seems to be an increase in the variety of cancers that individuals are contracting, from environmental to hereditary, etc. – Community Leader

Environmental Contributors

It seems that I personally know more and more people being diagnosed with cancer. I wonder if it's something environmental, as many don't have a family history. Having a superfund site in our county is concerning to me. – Health Provider

The chemicals in our foods, drinks, daily household items and more cause our community to have an increased risk of cancer. We have lost people in our community and currently have people battling cancer. – Health Provider

Tobacco Use

Surprisingly, a large percentage of cigarette and marijuana smokers and people who vape! Need more individuals (9 years to 45 years) to receive HPV vaccines. Not enough promotion of breast health. Need more encouragement for colonoscopies and Cologuard. Skin cancer education. – Public Health Representative

Access to Care/Services

Access and cost. – Social Services Provider

Diagnosis/Treatment

Early detection. – Community Leader

Prevention/Screenings

Ongoing story of families struggling with prevention and care. – Community Leader

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Note that this section also includes data relative to COVID-19 (coronavirus disease).

Age-Adjusted Respiratory Disease Deaths

Lung Disease Deaths

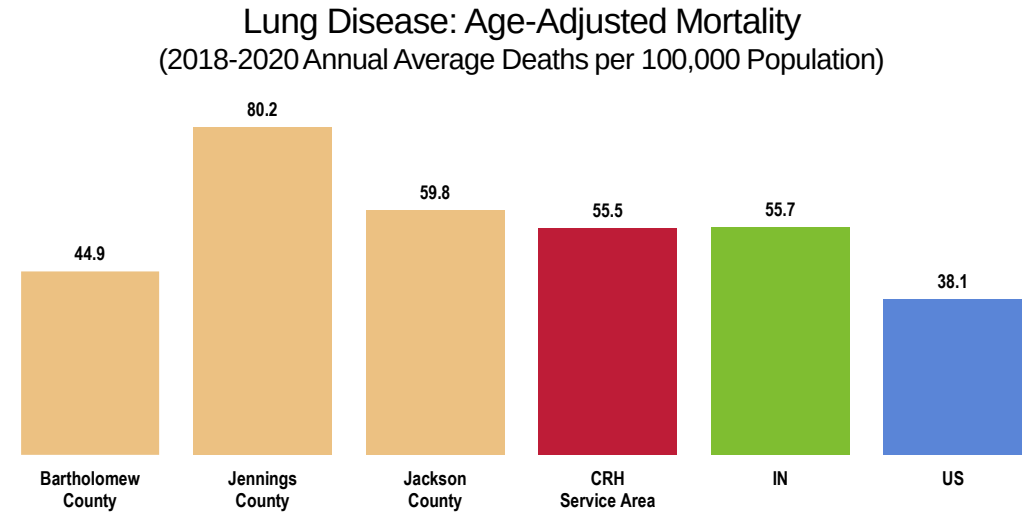
Note: Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

Between 2018 and 2020, the Columbus Regional Health Service Area reported an annual average age-adjusted lung disease mortality rate of 55.5 deaths per 100,000 population.

BENCHMARK ► Worse than the US rate.

TREND ► Decreasing significantly within the service area over time.

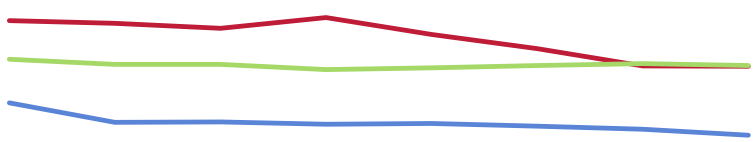
DISPARITY ► Highest in Jennings County.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes: ● Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Lung Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	67.0	66.3	65.1	67.8	63.5	59.9	55.6	55.5
IN	57.3	56.0	55.9	54.7	55.1	55.7	56.2	55.7
US	46.3	41.4	41.4	40.9	41.0	40.4	39.6	38.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

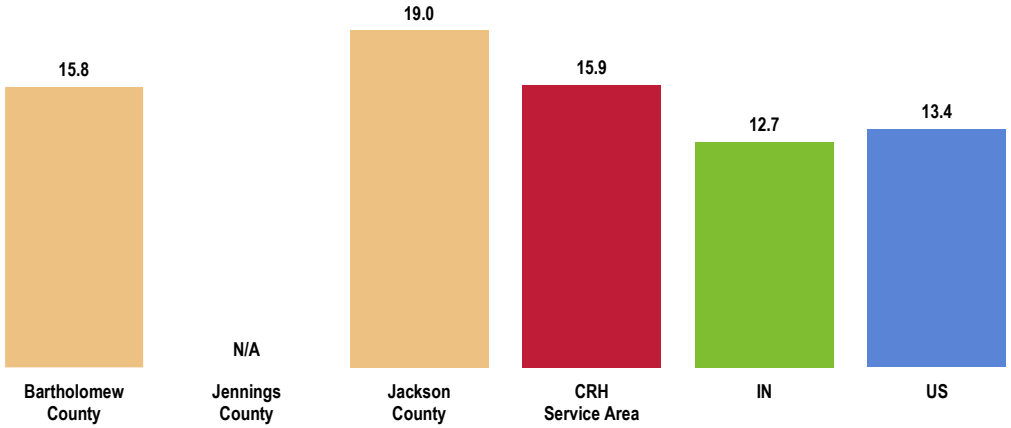
Pneumonia/Influenza Deaths

Between 2018 and 2020, the Columbus Regional Health Service Area reported an annual average age-adjusted pneumonia/influenza mortality rate of 15.9 deaths per 100,000 population.

BENCHMARK ► Worse than state and US rates.

TREND ► Rising significantly within the service area over time.

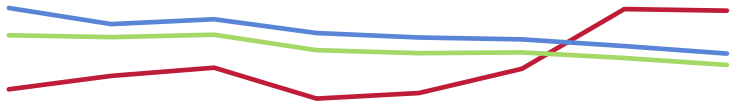
Pneumonia/Influenza: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



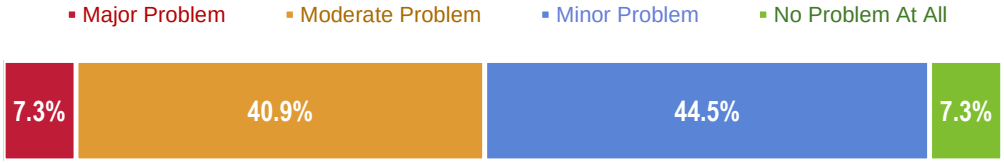
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	11.3	12.1	12.6	10.8	11.1	12.5	16.0	15.9
IN	14.5	14.4	14.5	13.6	13.4	13.5	13.1	12.7
US	16.1	15.1	15.4	14.6	14.3	14.2	13.8	13.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Respiratory Disease

Key informants taking part in an online survey generally characterized *Respiratory Disease* as a "moderate" or "minor" problem in the community.

Perceptions of Respiratory Disease as a Problem in the Community
(Key Informants; CRH Service Area, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> News articles. Hospital admissions. Increase in reported infections. – Community Leader
>
> A lot of adults are struggling with COPD, etc. Children seem to be struggling with more asthma, etc. – Health Provider

Tobacco Use

> Hereditary problems, smoking various types of dangerous chemicals, working in some industries where various types of fumes are inhaled on regular basis. – Community Leader

Due to COVID-19

> Respiratory illnesses in children have been drastically worse post-pandemic than it was prior to the pandemic. – Health Provider

E-Cigarettes

> The epidemic of vaping. – Community Leader

Environmental Contributors

> People who are affected by farm dust and chemicals. – Community Leader

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2018 and 2020, there was an annual average age-adjusted unintentional injury mortality rate of 69.0 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Higher than the national rate. Fails to satisfy the Healthy People 2030 objective.

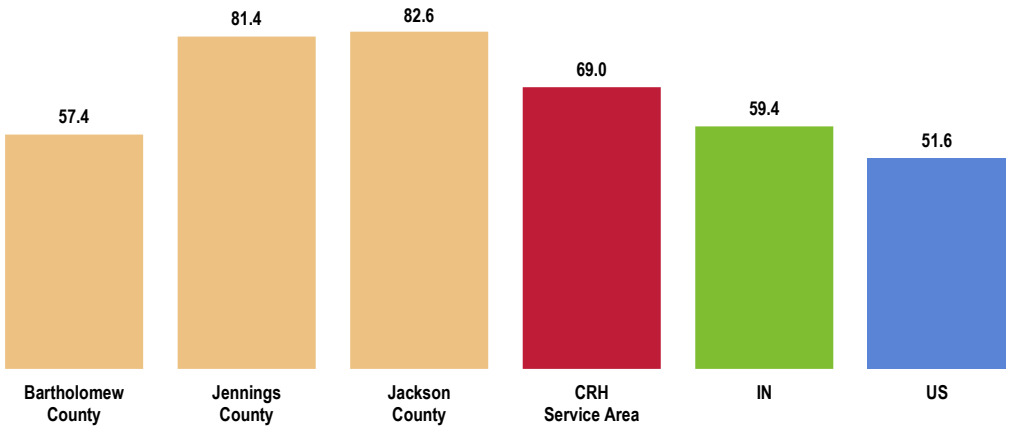
TREND ► Rising significantly within the service area over time.

DISPARITY ► Lowest in Bartholomew County.

Unintentional Injuries: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



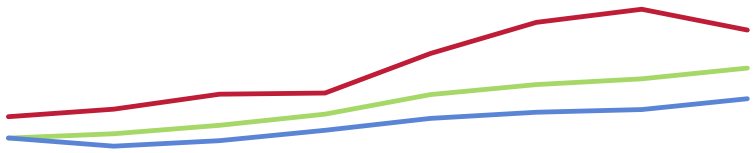
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	47.1	49.0	52.7	53.0	63.0	70.9	74.2	69.0
IN	41.7	42.8	44.9	47.7	52.7	55.2	56.6	59.4
US	41.7	39.7	41.0	43.7	46.7	48.3	48.9	51.6

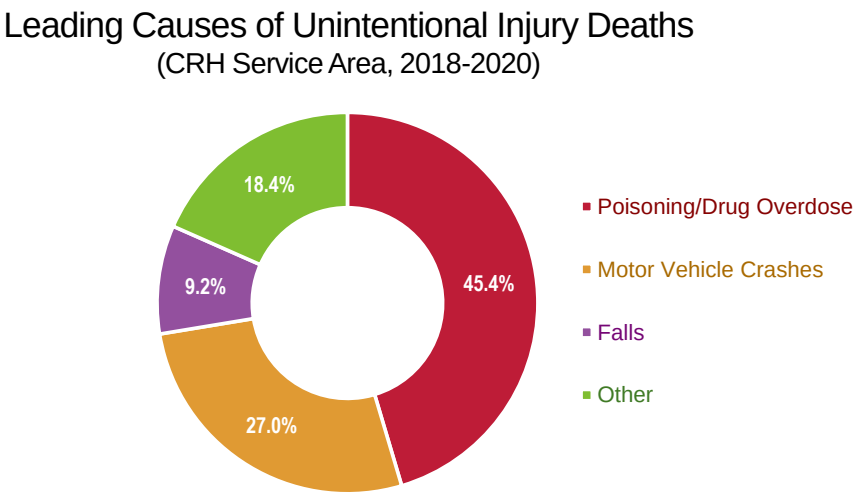
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

Poisoning (including unintentional drug overdose), motor vehicle crashes, and falls accounted for most unintentional injury deaths in the Columbus Regional Health Service Area between 2018 and 2020.



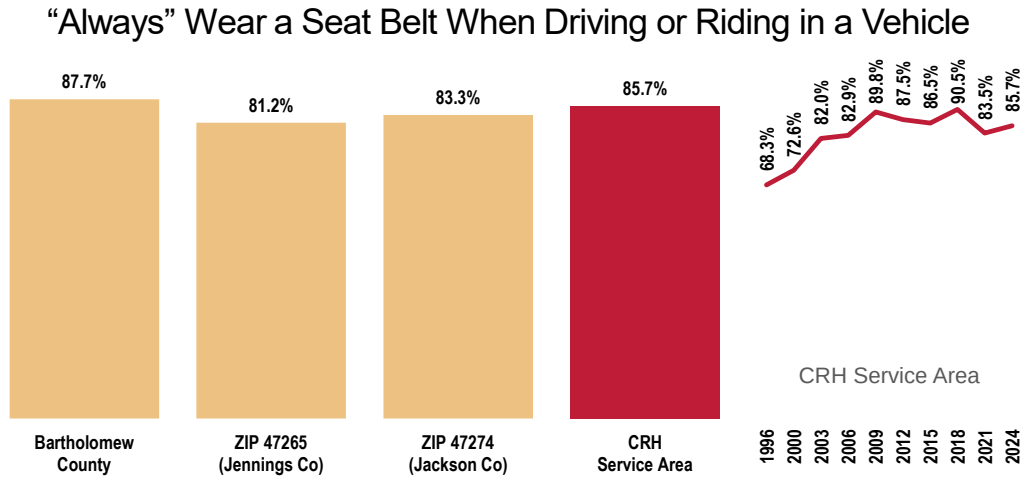
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Seat Belt Use

Most survey respondents (85.7%) report "always" using a seat belt when driving or riding in a vehicle.

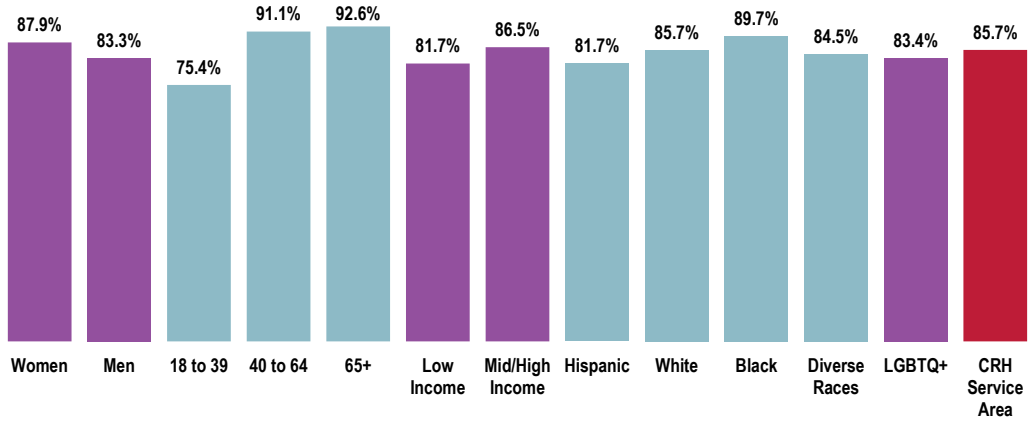
TREND ► Relatively stable in recent years, but significantly higher than the 1996 baseline.

DISPARITY ► Respondents age 18 to 39 are less likely to report using seat belts.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: ● Asked of all respondents.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

“Always” Wear a Seat Belt When Driving or Riding in a Vehicle
(CRH Service Area, 2024)



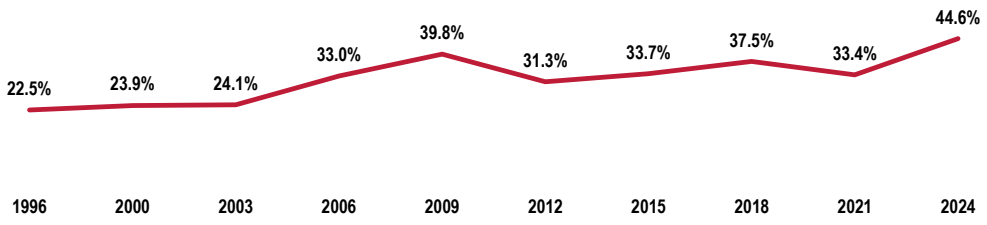
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Bicycle Helmet Use

Among service area residents with children age 5 to 17, 44.6% report that their child “always” wears a helmet when riding a bike.

TREND ► Rising significantly to the highest level recorded since 1996.

Child “Always” Wears a Helmet When Riding a Bicycle
(CRH Service Area Children Age 5-17)



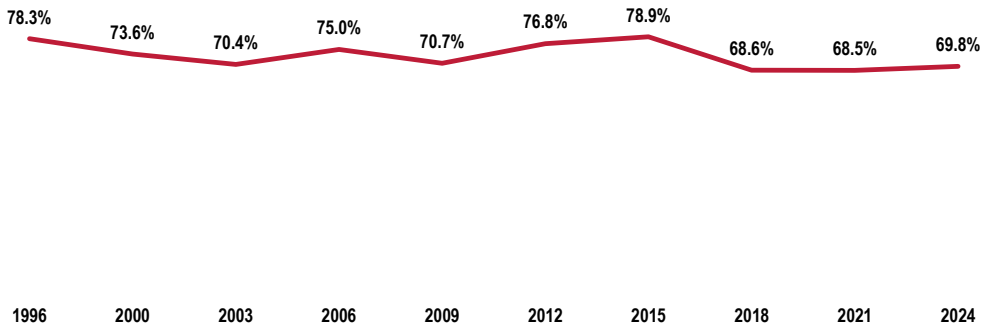
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 343]
Notes: ● Asked of all respondents with children age 5 to 17 at home.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Water Safety

Among service area residents with children age 5 to 17, 69.8% report that their child has ever received instruction in swimming or water safety.

TREND ► Marks a significant decrease from the 1996 baseline.

Child Has Received Instruction in Swimming or Water Safety
(CRH Service Area Children <18)



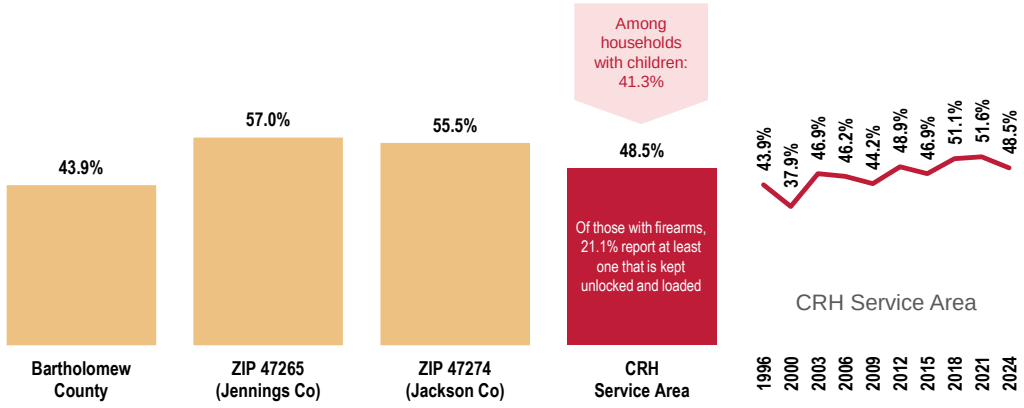
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 342]
Notes: ● Asked of all respondents with children under 18 at home.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Firearms

A total of 48.5% of Columbus Regional Health Service Area adults have a firearm kept in or around the home (including 41.3% among households with children); of these residents, 21.1% report that the gun is kept loaded and unlocked.

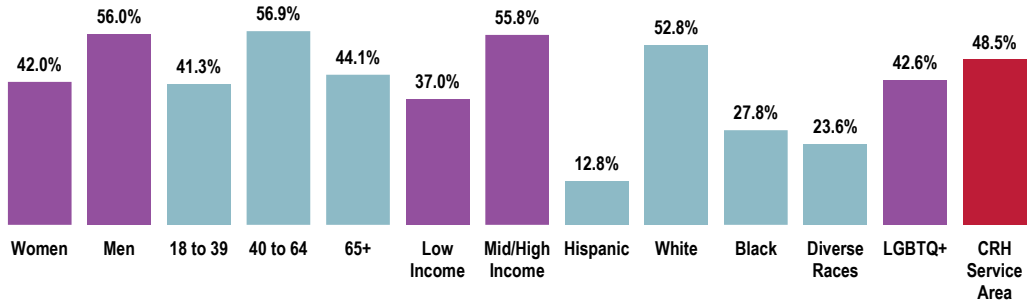
DISPARITY ► Lowest in Bartholomew County. More often reported among men, residents age 40 to 64, those with higher incomes, White respondents, and respondents of diverse races.

Have a Firearm Kept In or Around the Home



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 307, 346-347]
Notes: ● Asked of all respondents.
● In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Have a Firearm Kept In or Around the Home
(CRH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 307]

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Intentional Injury (Violence)

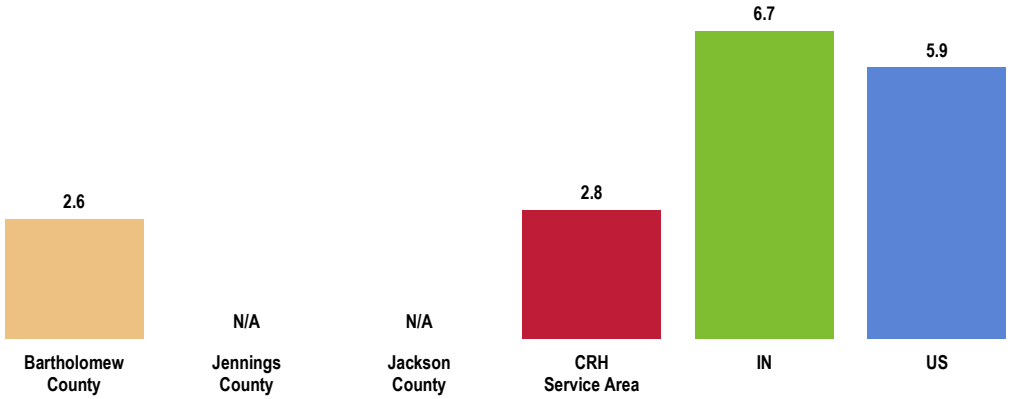
Age-Adjusted Homicide Deaths

In the Columbus Regional Health Service Area, there were 2.8 homicides per 100,000 population (2011-2020 annual average age-adjusted rate).

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

BENCHMARK ► Lower than state and national rates. Satisfies the Healthy People 2030 objective.

Homicide: Age-Adjusted Mortality
(2011-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent Crime Rates

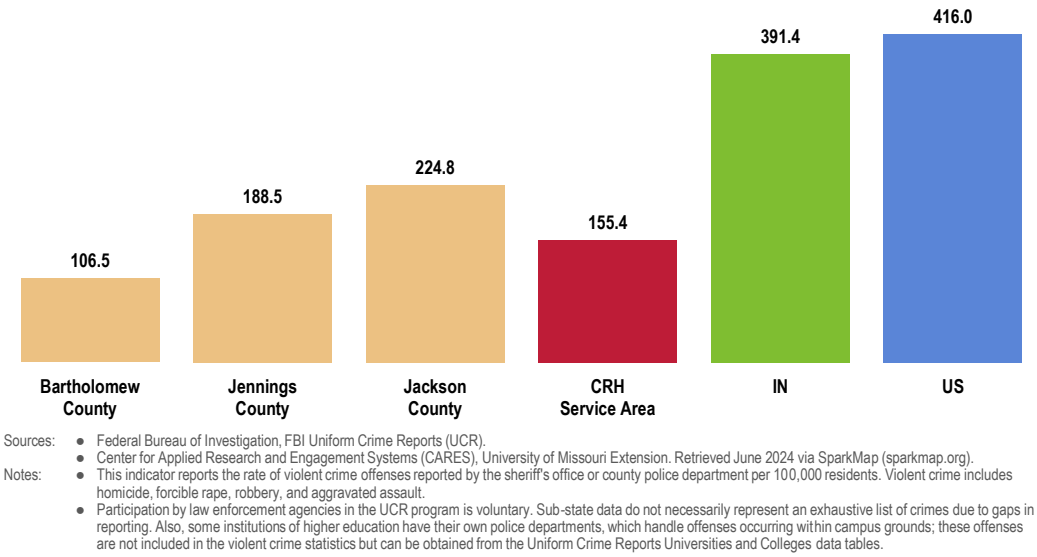
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Between 2015 and 2017, the Columbus Regional Health Service Area reported 155.4 violent crimes per 100,000 population.

BENCHMARK ► Considerably lower than found across Indiana and the US.

DISPARITY ► Highest in Jackson County.



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, forcible rape, robbery, and aggravated assault.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Intimate Partner Violence

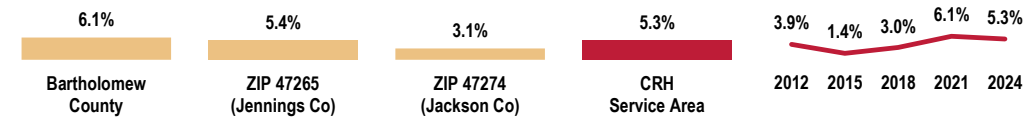
Respondents were read: "By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 5.3% of Columbus Regional Health Service Area adults acknowledge that they have been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner in the past three years.

DISPARITY ► More often reported among women, adults younger than 65, those with lower incomes, residents of diverse races, and LGBTQ+ respondents.

Have Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner in the Past 3 Years

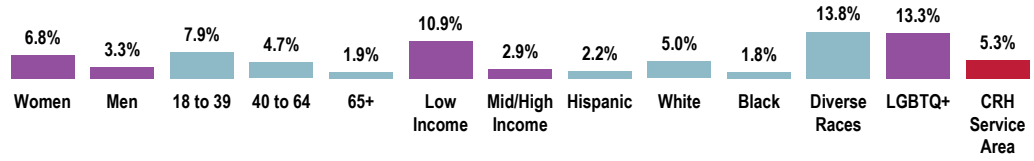
CRH Service Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: • Asked of all respondents.

Have Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner in the Past 3 Years

(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: • Asked of all respondents.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Emotional Harm/Control

"In the past three years, has an intimate partner hurt you emotionally through put-downs or belittling, isolated you from friends and family, or tried to control you or your finances?"

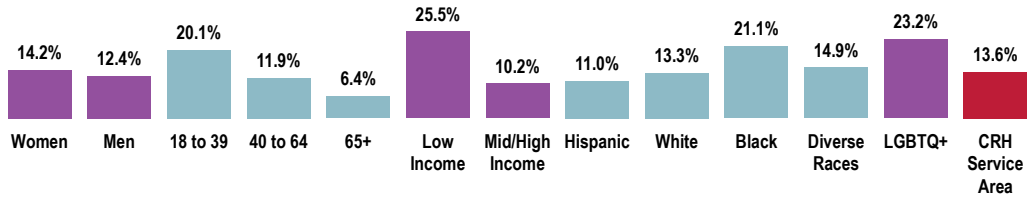
A total of 13.6% of surveyed adults acknowledge that an intimate partner has hurt them emotionally, isolated them, or attempted to control them in the past three years.

DISPARITY ► More often reported among adults younger than 65, those with lower incomes, and LGBTQ+ respondents.

Have Been Hurt Emotionally or Controlled by an Intimate Partner in the Past 3 Years

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: • Asked of all respondents.
• Includes instances of put-downs or belittling, isolation from friends and family, personal control, and/or financial control.

Have Been Hurt Emotionally or Controlled by an Intimate Partner in the Past 3 Years
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: • Asked of all respondents.
• Includes instances of put-downs or belittling, isolation from friends and family, personal control, and/or financial control.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

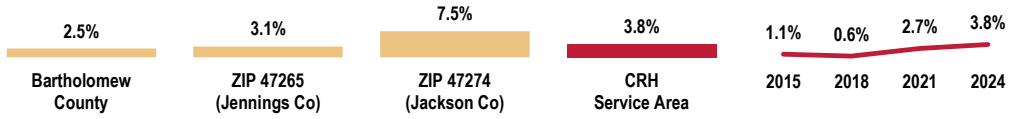
Sexual Violence

A total of 3.8% of service area respondents report that someone has forced them to engage in sexual activity that they did not want at some point in the past three years.

TREND ► Trending significantly higher over time.

Have Been Forced Into Sexual Activity in the Past 3 Years

CRH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

Key informants taking part in an online survey most often characterized *Injury & Violence* as a "moderate problem" in the community.

Perceptions of Injury & Violence as a Problem in the Community
(Key Informants; CRH Service Area, 2024)

Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Homicides have increased, and the need for domestic violence services are at capacity. – Community Leader
>
> The number of domestic violence and assault charges are ongoing and too high. It seems like these are always popping up in the newspaper. – Community Leader
>
> Domestic violence is becoming more lethal. – Social Services Provider
>
> Prevalence of gun violence in general, and prevalence of domestic violence. Statistics as well as anecdotes and media coverage. – Health Provider

Co-Occurrences

> It seems with increased mental health disorders and also increased drug usage, this is a growing problem. Also, accessibility and lack of awareness associated with firearms. – Community Leader

Government/Policy

> Gun violence has increased with the state legislature's elimination of a requirement of licensing. Juveniles have access to guns in homes, children have access to guns in homes. A drive-by shooting occurred in a public park in Columbus in 2023. – Community Leader

Vulnerable Populations

> Frequent aggressions among the unhoused community go unattended due to a lack of insurance. – Social Services Provider

Gun Violence

> Increased use of guns. – Community Leader

Alcohol/Drug Use

> Substance abuse and low income. – Community Leader

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

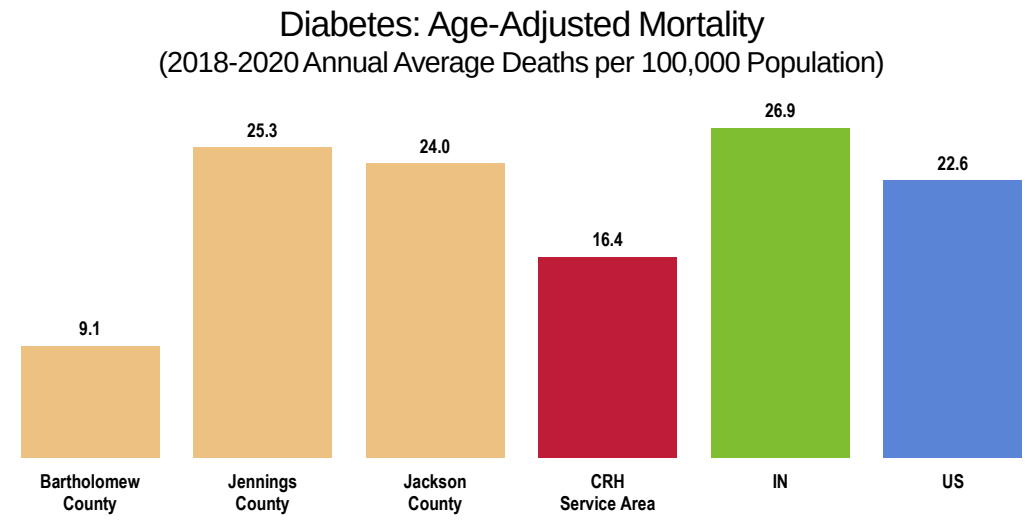
Age-Adjusted Diabetes Deaths

Between 2018 and 2020, there was an annual average age-adjusted diabetes mortality rate of 16.4 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Lower than found across the state and nation.

TREND ► Declining significantly within the service area.

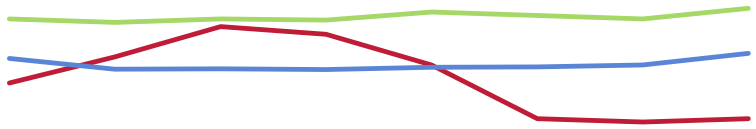
DISPARITY ► Lowest in Bartholomew County.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Diabetes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	19.8	22.3	25.1	24.4	21.5	16.4	16.1	16.4
IN	25.9	25.5	25.9	25.8	26.5	26.2	25.9	26.9
US	22.1	21.1	21.1	21.1	21.3	21.3	21.5	22.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Diabetes

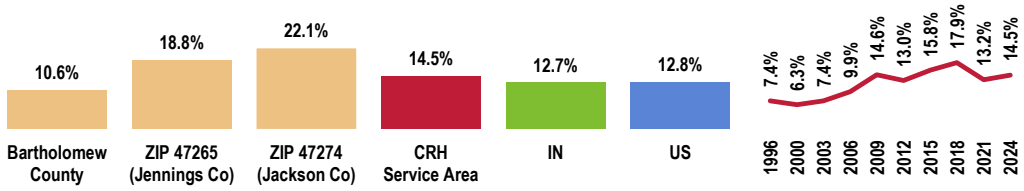
A total of 14.5% of Columbus Regional Health Service Area adults report having been diagnosed with diabetes.

TREND ► Denotes a significant increase from the 1996 baseline.

DISPARITY ► Highest in Jackson County ZIP Code 47274. More often reported among men, adults age 40+, and White respondents.

Prevalence of Diabetes

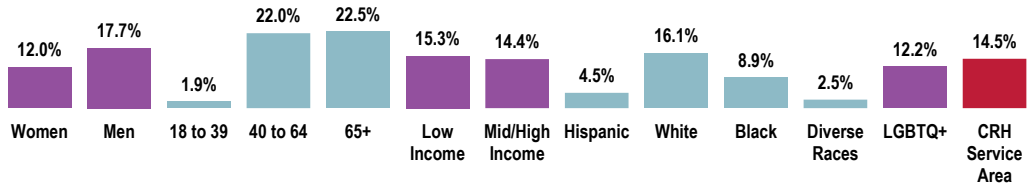
CRH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 27]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Prevalence of Diabetes
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 27]
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Age-Adjusted Kidney Disease Deaths

ABOUT KIDNEY DISEASE & DIABETES

Chronic kidney disease (CKD) is common in people with diabetes. Approximately one in three adults with diabetes has CKD. Both type 1 and type 2 diabetes can cause kidney disease. CKD often develops slowly and with few symptoms. Many people don't realize they have CKD until it's advanced and they need dialysis (a treatment that filters the blood) or a kidney transplant to survive.

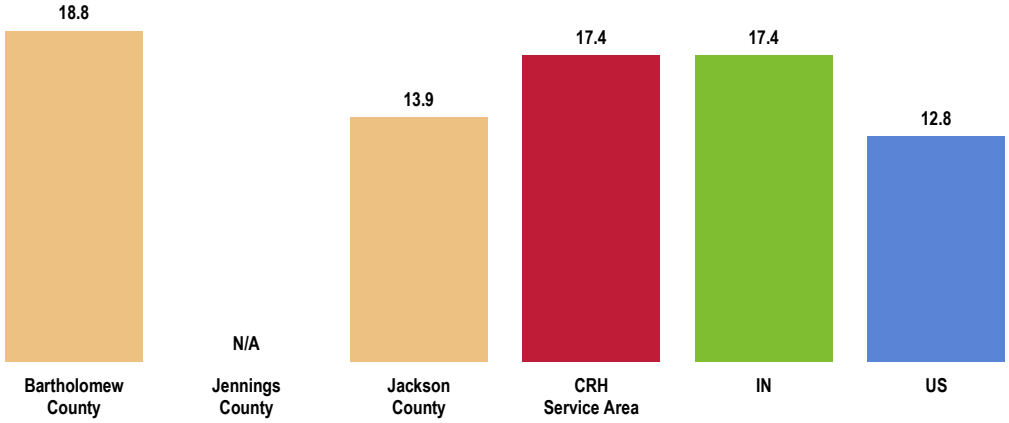
– Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html

Between 2018 and 2020, there was an annual average age-adjusted kidney disease mortality rate of 17.4 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Worse than the US rate.

DISPARITY ► Highest in Bartholomew County.

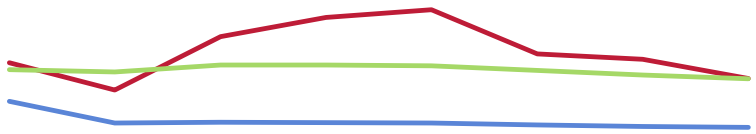
Kidney Disease: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Kidney Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



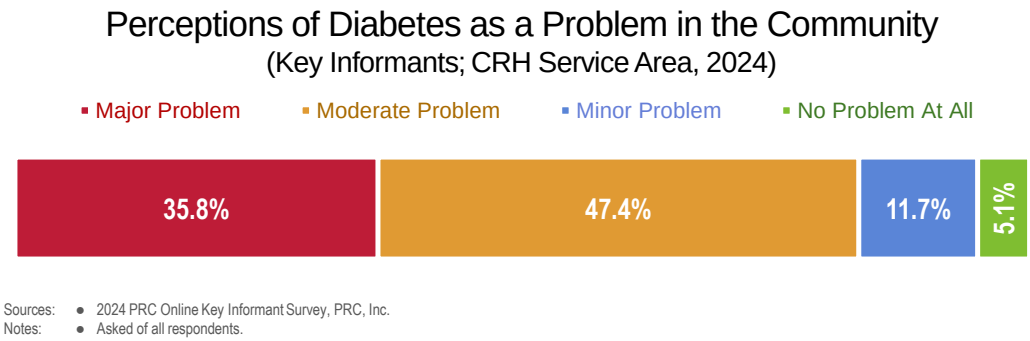
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	18.9	16.3	21.4	23.2	23.9	19.7	19.2	17.4
IN	18.2	18.0	18.7	18.7	18.6	18.2	17.7	17.4
US	15.2	13.2	13.3	13.2	13.2	13.0	12.9	12.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Diabetes

Key informants taking part in an online survey generally characterized *Diabetes* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

> I think the biggest challenge is access to healthy foods or foods that are appropriate for individuals living with diabetes. I also think there needs to be more education surrounding diabetes and what nutrition can be helpful. – Community Leader
>
> Healthy food options at affordable rates, affordable access to gyms and fitness centers. – Community Leader
>
> Being able to afford and have access to nutritional food, knowing what nutritional food is, and understanding the appropriate diet for their diagnosis. – Health Provider
>
> Lack of resources or options for healthy eating options at affordable prices. Lifestyles and responsibilities that do not allow for adequate rest, activity, and healthy eating habits. – Physician
>
> Access to nutritious foods and insulin. – Community Leader
>
> For those developing it due to diet, access to affordable fresh foods. Lack of activity, laziness, poor nutrition education, depression, mental health challenges. – Community Leader
>
> Accessing healthy foods and opportunities for physical activity. – Health Provider
>
> Access and affordability of good foods, support, and education. – Health Provider

Awareness/Education

> Education about causes and treatments, other than insulin or medication. Prevention. – Physician
>
> Lack of knowledge about the disease, and role of healthy diet and exercise. Cost of medicines, like insulin. – Physician
>
> People with diabetes understand their disease. – Social Services Provider
>
> Lack of education, lack of referral options for newly diagnosed and low-income. – Health Provider
>
> Treatment options, including clarity about nutrition plans. – Community Leader
>
> Education, good food choices, lack of exercise, lack of motivation to improve their health. – Public Health Representative
>
> There are so many who are affected by diabetes. I think there needs to be more awareness and energy aimed to prevent going into the world of diabetes whenever possible. Diets, groceries, cooking, food, and lifestyle choices should be emphasized. – Community Leader
>
> I understand that diabetes is a big problem in our community and that a key success factor is providing coaching or navigation to patients to ensure they are following health recommendations from their provider. – Community Leader

Nutrition

> Not eating a healthy diet. Not getting enough exercise. – Community Leader
>
> People, me included, don't have access to foods that aren't packed with sugar. I think that if dietary information was made more accessible, the risk of diabetes would lessen. – Community Leader
>
> Food insecurity, poor habits, and unhealthy fast-food options. – Health Provider
>
> Healthy nutrition, good health habits. – Community Leader

> Eating correctly, taking medications as prescribed. – Community Leader
>
> Good nutrition and the mental health stability to be compliant. – Community Leader

Affordable Medications/Supplies

> Access to medications, cost of medications, and availability to care, the time it takes to get an appointment. – Community Leader
>
> Cost of medication, access to care, poor food options, and testing supply expenses. – Health Provider
>
> Cost and access to medications and testing supplies. Support for behavioral changes that would assist with treatment. Diet, exercise, and wound management. – Health Provider
>
> Affording medications. – Community Leader
>
> Medication costs. – Social Services Provider

Obesity

> When I look around, I see a lot of obesity in this community. Lack of access to affordable, healthy food. Lack of education. – Community Leader
>
> Obesity and an environment in Bartholomew County that does not make it easy to be healthy. – Health Provider
>
> Overweight, improper diet, lack of exercise, not following medical recommendations. – Community Leader
>
> 37% of the population are evaluated as “obese” in Bartholomew County! Nutritional education; portion control; importance of exercise! Excessive fast food available in Bartholomew County! Insulin (type 1) is expensive, and many individuals do not have health care coverage. – Public Health Representative

Lifestyle

> Effectively making and community supporting lifestyle changes to prevent the onset of diabetes. – Health Provider
>
> The healthy option is not the easy option, and lack of physical activity. – Community Leader
>
> Diet, exercise, and overall knowledge. – Community Leader

Access to Care/Services

> Access to the supports, such as financial, personal, etc. that they need to manage their disease. Lack of knowledge of the cause and prevention of type 2 diabetes. The community has not made a commitment to make the healthy choice the easy choice. – Health Provider
>
> The diabetes clinic needs to have a physician referral and not just a resource for people to be able to go on their own. – Public Health Representative

Affordable Care/Services

> Options to effectively and affordably manage this chronic disease. – Health Provider

Disease Management

> Management of the disease while living full, productive lives. Management of the disease to avoid complications, which contribute to morbidity and mortality. – Community Leader

Vulnerable Populations

> Immigrants coming in with uncontrolled diabetes and finding providers that will see them with no insurance and no Medicaid. – Public Health Representative

Incidence/Prevalence

> Increasing numbers of people with type 2 diabetes. – Community Leader

Insurance Issues

> Securing appropriate and inclusive health insurance. Finding the physician that will be available to them for the long haul. Maintaining an appropriate diet. – Community Leader

Lack of Proper Management Practices

> Proper management practices and continuity of care. – Community Leader

DISABLING CONDITIONS

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

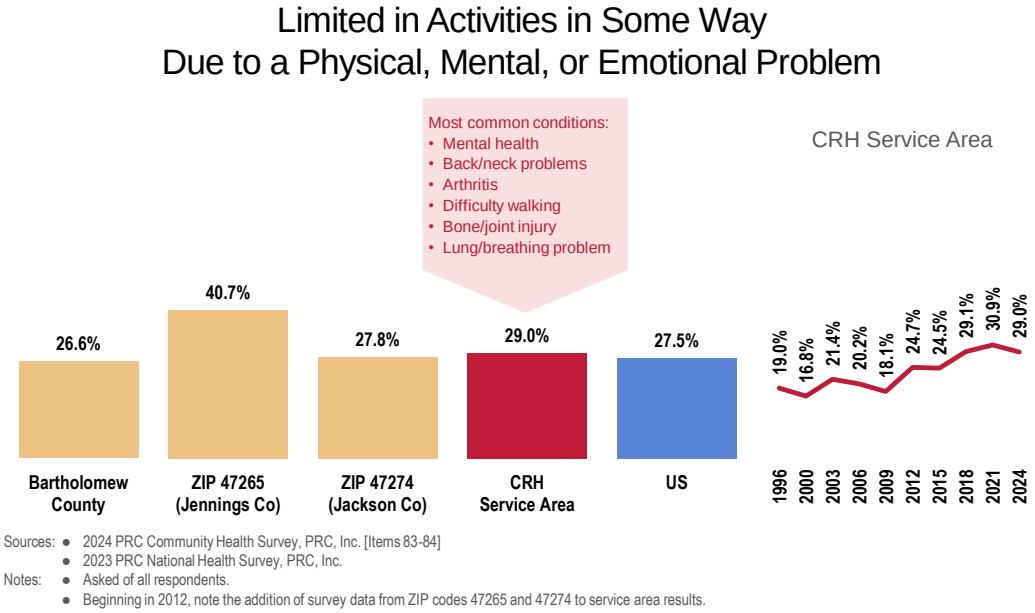
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

A total of 29.0% of Columbus Regional Health Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

TREND ► Trending significantly higher over time.

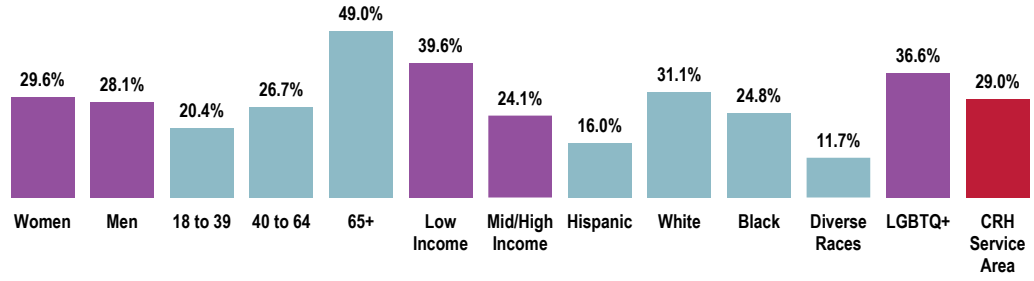
DISPARITY ► Highest in Jennings County ZIP Code 47265. More often reported among adults age 40+ (particularly those age 65+), lower-income respondents, and White residents.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 83-84]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Limited in Activities in Some Way
Due to a Physical, Mental, or Emotional Problem
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia. Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

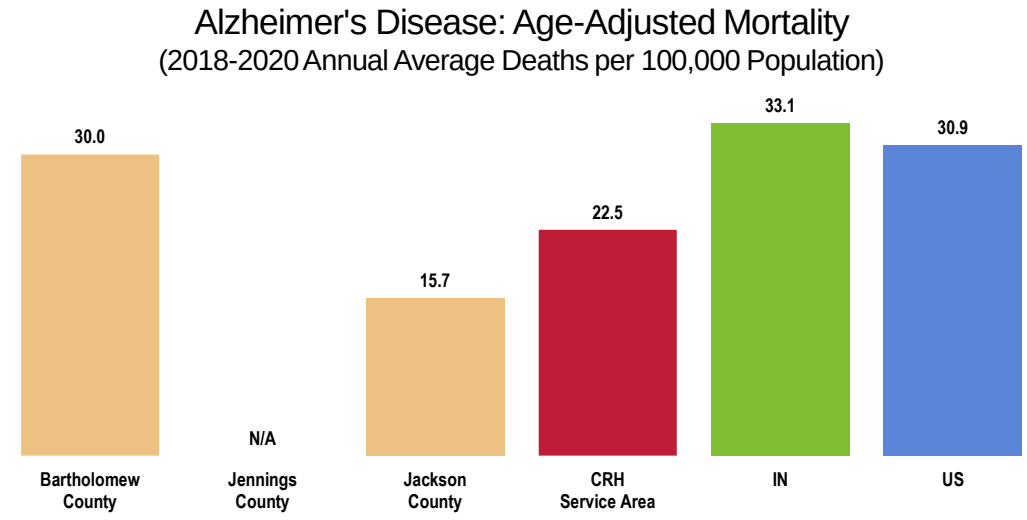
Age-Adjusted Alzheimer's Disease Deaths

Between 2018 and 2020, there was an annual average age-adjusted Alzheimer's disease mortality rate of 22.5 deaths per 100,000 population in the Columbus Regional Health Service Area.

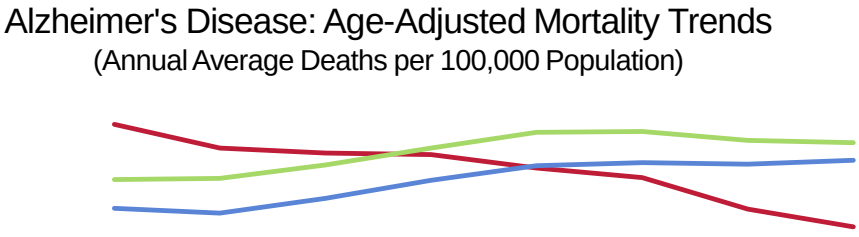
BENCHMARK ► Lower than Indiana and US rates.

TREND ► Declining significantly to the lowest level recorded in nearly a decade.

DISPARITY ► Highest in Bartholomew County.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.



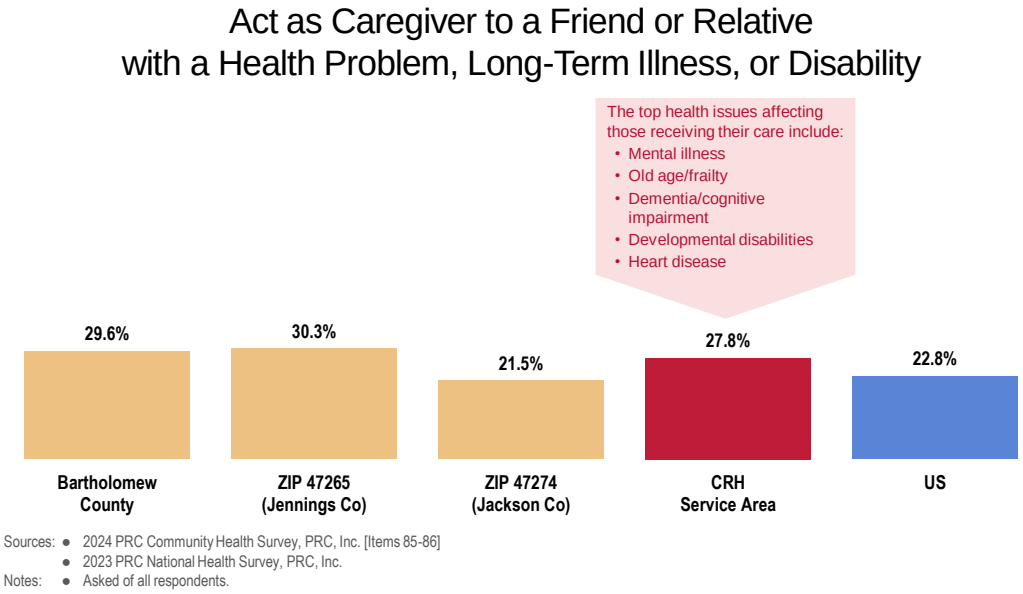
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	35.4	32.5	31.8	31.6	29.9	28.7	24.8	22.5
IN	28.5	28.6	30.3	32.5	34.4	34.5	33.4	33.1
US	24.8	24.2	26.1	28.4	30.2	30.6	30.4	30.9

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Caregiving

A total of 27.8% of Columbus Regional Health Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

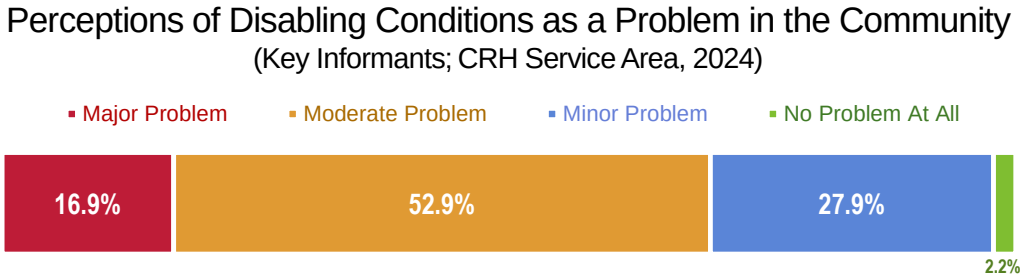
BENCHMARK ▶ Higher than found nationally.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

The greatest share of key informants taking part in an online survey characterized *Disabling Conditions* as a "moderate problem" in the community.



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

> We have an aging population. – Social Services Provider
>
> These conditions are common among aging and high-risk populations. Being intentional about good health practices does not come easily to many, or possibly cannot be avoided. – Community Leader
>
> A huge increase in dementia, and baby boomers are aging. – Community Leader

> As our population ages, dementia and hearing loss are a problem. Providers need to check older patients' hearing – quick check in ears to see if they need irrigating to clean, refer to hearing specialist. When elderly do not hear well, they disengage and withdraw. More programs are needed to get the aging population up and moving. Programs need to happen where these people live. i.e.: subsidized apartments, workplaces. – Public Health Representative
>
> These health issues affect many ages, but the elderly specifically. Again, more efforts in prevention of suffering from the worst symptoms, more information on available options for help, assistance for low-income. – Community Leader

Access to Care/Services

> 30% of adults in our county are disabled. Being disabled is NOT a major problem. Lack of accessibility IS. I am disabled and have to remind doctors' offices and city employees at public events of basic ADA requirements. Not all health conditions or disabilities are avoidable/bad (see research on social determinants of health) but being excluded/treated like a burden is completely avoidable. Instead of trying to make people less disabled, this community needs to focus on becoming more livable for the 30% to 50% of adults living with illness/disease/disability. Over the next 15 years, more boomers will become disabled. We need to be aware of the "disability paradox." People with severe and permanent limitations assess their own quality of life as (very) good, yet it is perceived much more negatively by external observers. Health is not necessarily related to an objectively good/measurable state of health, but rather reflects a balance between psychological and physical quality of life. – Community Leader
>
> In particular, there is little available to help people dealing with chronic pain. – Physician
>
> Difficulty accessing services and support needed. – Community Leader

Falls

> Research shows falls are the top unintentional injury for people over 65, and fall-related deaths increased 30% between 2009 and 2018. The hospitalization cost of a fall averages $30,000 per person. In February 2024, Indiana's Division of Aging sent a notice to Medicaid Home and Community Based Services stating, "The Division of Aging recently conducted an audit of unexpected, preventable deaths of participants […] and found that of those deaths which were unexpected and preventable, roughly 27% occurred as the result of a fall with injury." The Division of Aging recommended providers provide evidence-based fall prevention if able. The STEADI program through the CDC is a great tool CRH and Healthy Communities should invest in. A fall prevention specialist could really help lower fall rates/deaths in home and community-based services like adult day, assisted living, and low-income apartment complexes. This must be a community conversation in the next 15 years. – Community Leader

Alcohol/Drug Use

> We have substance abuse problems, which might be related to chronic pain. Lack of access to mental health services causes people to self-medicate. Affordable or access to health insurance. – Community Leader

Diagnosis/Treatment

> Dementia progression and other disabilities are often hidden until a crisis. Services are not easily coordinated and variably accessible. – Physician

Co-Occurrences

> Mental health has been on the decline since the pandemic occurred. Morbid obesity is on the rise, pulmonary embolisms are on the rise, cardiomyopathy and other heart related issues have come into the limelight since COVID-19. – Community Leader

Caregiver Support

> Elder/disabled care – families are stressed trying to take care of elderly/disabled people and cannot afford the support they need. Most people work and do not have a person at home to care for them. Institutional care is difficult if your person is over income for Medicaid but unable to afford to pay out of pocket. Mostly adult women are impacted by this "invisible" unpaid caregiving. – Health Provider

Incidence/Prevalence

> Increasing evidence of Alzheimer's and other forms of dementia. – Community Leader

Income/Poverty

> I think disabilities are a major concern because individuals with disabilities do not receive the income needed to survive. – Social Services Provider

Awareness/Education

> Need more information and resources. – Community Leader

BIRTHS

BIRTH OUTCOMES & RISKS

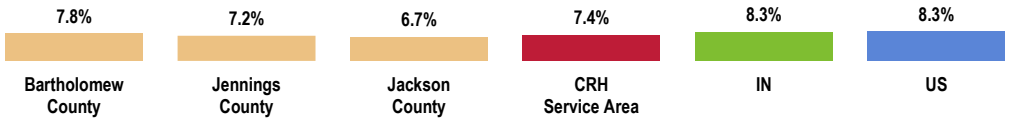
Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 7.4% of 2016-2022 Columbus Regional Health Service Area births were low-weight.

Low-Weight Births
(Percent of Live Births, 2016-2022)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

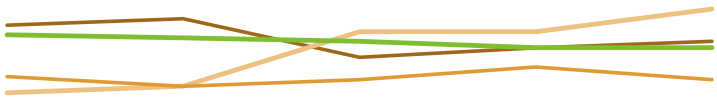
Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2018 and 2022, there was an annual average of 7.0 infant deaths per 1,000 live births in Bartholomew County.

BENCHMARK ► Worse than the national rate (5.6). Fails to satisfy the Healthy People 2030 objective.

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower



	2014-2018	2015-2019	2016-2020	2017-2021	2018-2022
Bartholomew	7.5	7.7	6.5	6.8	7
Jennings	5.4	5.6	7.3	7.3	8.0
Jackson	5.9	5.6	5.8	6.2	5.8
IN	7.2	7.1	7.0	6.8	6.8

Sources:
- Indiana Department of Health. https://www.in.gov/health/mch/data/birth-outcomes-and-infant-mortality-dashboard/

Notes:
- Rates are five-year averages of deaths of children under 1 year old per 1,000 live births.

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

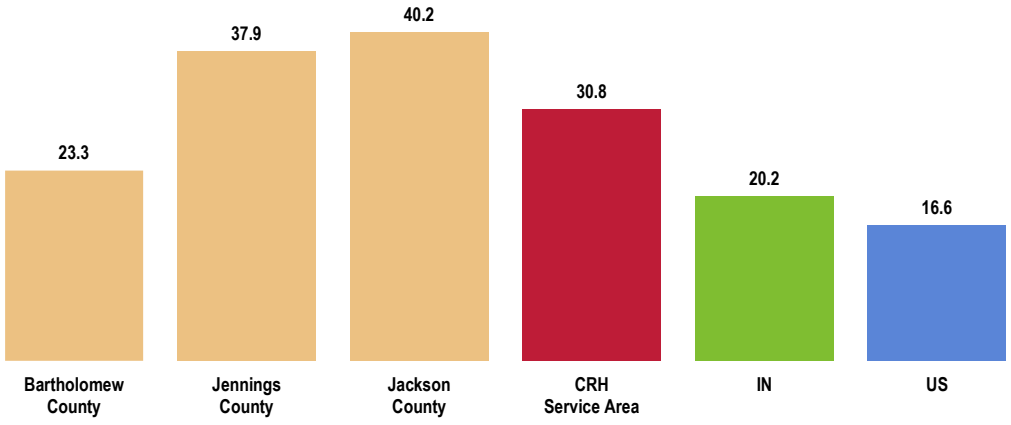
Between 2016 and 2022, there were 30.8 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Columbus Regional Health Service Area.

BENCHMARK ► Higher than found statewide and nationally.

DISPARITY ► Lowest in Bartholomew County.

Teen Birth Rate

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2016-2022)

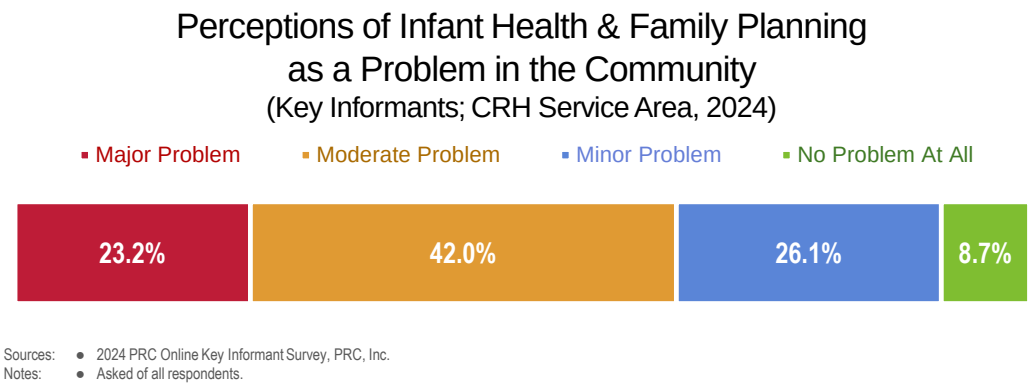


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Key Informant Input: Infant Health & Family Planning

Key informants taking part in an online survey generally characterized *Infant Health & Family Planning* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> We only have one obstetrics office, and they are in town one day a week. – Health Provider
>
> Family planning is not easily accessible. – Social Services Provider
>
> Mothers do not have established care after six-week postpartum checks, and often will skip that visit due to income related issues. – Health Provider
>
> Lack of programs for prenatal care and maternal support. The existing funding is not sufficient to provide services to lower-income and uninsured. – Community Leader
>
> Access to care and prevention of unwanted pregnancies. – Community Leader
>
> Family planning is a problem (not infant health). One – we live in Indiana, so family planning is limited to non-abortion alternatives. Two – proper sex ed is not taught in the schools and is heavily abstinence-based rather than factual. One good development has been the availability of long-term birth control options for women and the expansion of Medicaid for adults to increase coverage. – Health Provider
>
> There are no midwifery models of care in Columbus. Midwifery models of care work. – Community Leader

Awareness/Education

> A great number of clients that we are seeing in our practice are not educated in this area and are not aware of resources or how to access them. – Health Provider
>
> There is no effective sex education in our schools, and teenagers lack knowledge about and access to contraception. We have a high rate of teenagers having babies and not being equipped to care for them. Our child care options are abysmal. – Physician
>
> Bartholomew County has been, in the past, leading the state in infant mortality. However, strides have been made to educate lower income families on safe sleep. – Community Leader
>
> Lack of education about family planning and infant health. Reaching people, males and females, in childbearing ages. – Social Services Provider

Infant Mortality

> The infant mortality rate is improving but is still too high. – Community Leader
>
> High mortality rate. – Community Leader
>
> High infant mortality rate, lack of OB/GYN physicians in the community, the state's current abortion bans and its effect on women's health care, including preventing necessary health care in the event of miscarriage or other issues affecting both mother and baby. – Community Leader
>
> Data for the state and county indicate that mortality rates are high, and measures of health and wellness are low compared to peers. – Health Provider
>
> There has been an increase in infant death in the county. – Public Health Representative

Government/Policy

> Women's health and women's rights are being attacked at the political level. Since when did a woman having access to family planning care become a political platform? Women should have access to whatever they need or want for their bodies. – Community Leader

> Far right-driven limitations on reproductive health. – Community Leader

Income/Poverty

> Many families are having babies very close together in age, which causes financial strain and makes it difficult for parents to go back to work. – Physician

Teen Parents

> Within Columbus, Indiana teenagers and/or immature adults (age 20 to 25) are having children. In many cases, they aren't responsible for their careless behaviors. Children trying to raise children. A newly-born child will grow up without receiving adequate parental and educational skills. A child could become like its parent if someone doesn't intercede to help educate both parties. – Community Leader

Unplanned Pregnancy

> Unplanned pregnancies are high, preconception counseling rates are low, and infant mortality rate has been high recently. – Health Provider

Vulnerable Populations

> I understand that our community has a higher-than-average infant mortality rate. I understand that this is higher for the Black and Black-biracial community. – Community Leader

Access to Care for Uninsured/Underinsured

> Lack of providers for those without insurance. – Public Health Representative

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

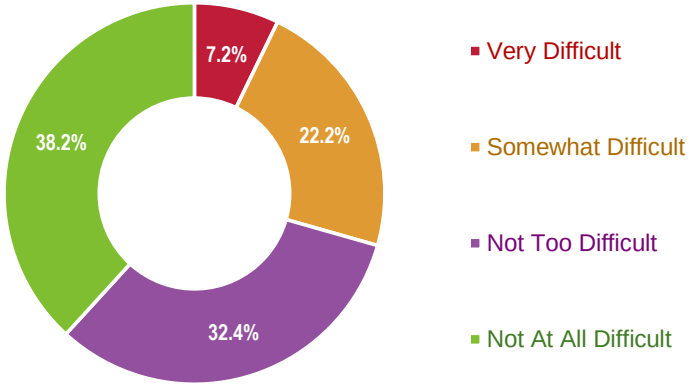
Difficulty Accessing Fresh Produce

Most Columbus Regional Health Service Area adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked, "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say very difficult, somewhat difficult, not too difficult, or not at all difficult?"

RELATED ISSUE
See also *Food Access* in the **Social Determinants of Health** section of this report.

Level of Difficulty Finding Fresh Produce at an Affordable Price
(CRH Service Area, 2024)

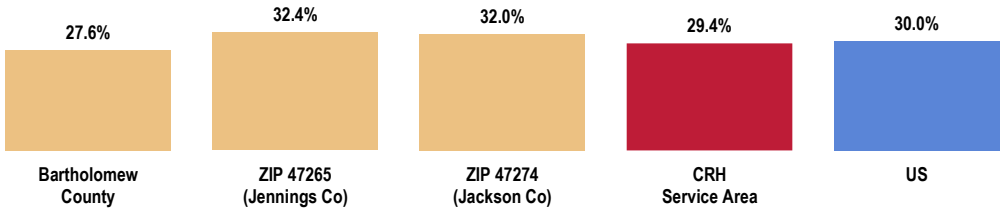


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

However, 29.4% of service area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

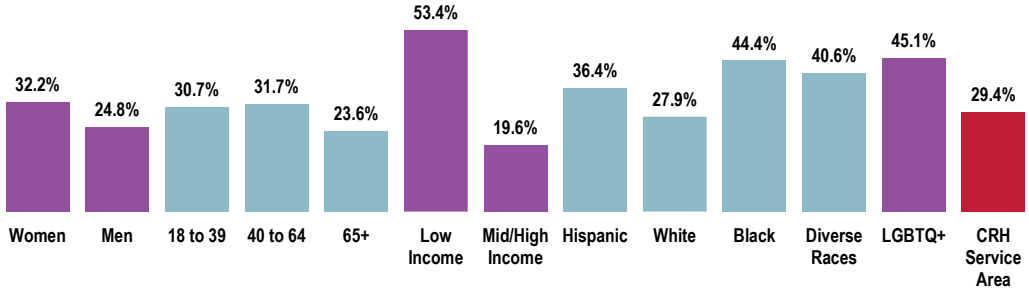
DISPARITY ► More often reported among women, adults younger than 65, lower-income households (especially), respondents who are Black or African American or of diverse races, and LGBTQ+ respondents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(CRH Service Area, 2024)



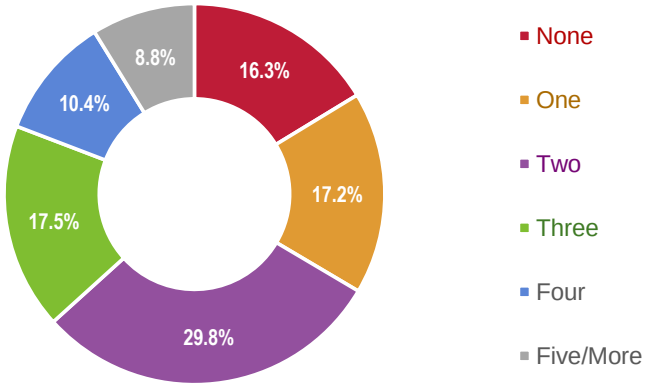
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Daily Recommendation of Fruits/Vegetables

A total of 8.8% of Columbus Regional Health Service Area adults report eating five or more servings of fruits and/or vegetables on the day prior to the interview.

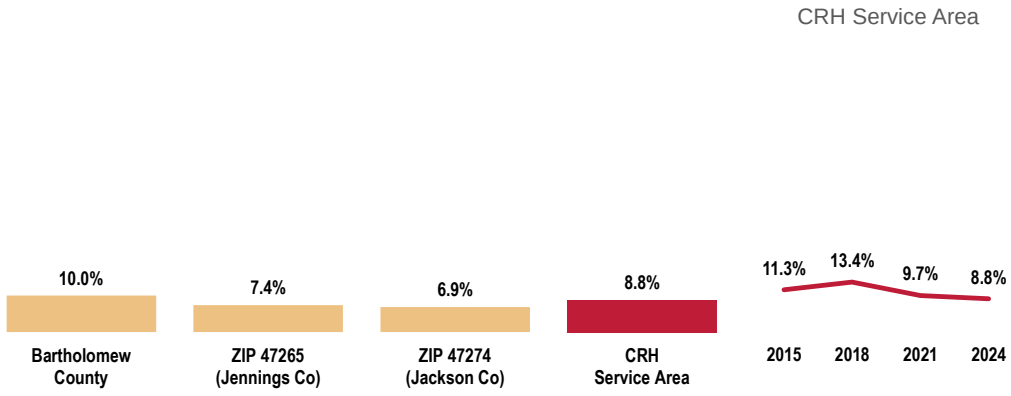
DISPARITY ► Those less likely to report fruit and vegetable consumption include men, adults younger than 65, lower-income residents, and respondents of diverse races.

Servings of Fruits and Vegetables Eaten Yesterday
(CRH Service Area, 2024)



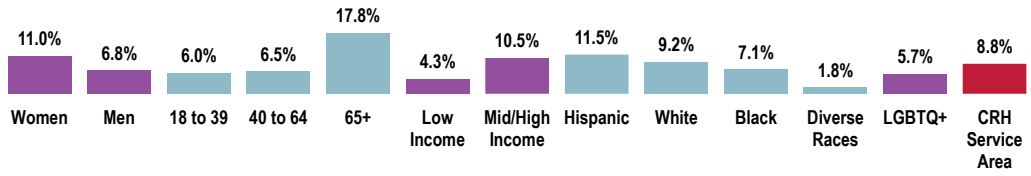
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents.

Ate 5+ Servings of Fruits and Vegetables Yesterday



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents.
• For this issue, respondents were asked to recall their food intake on the previous day.

Ate 5+ Servings of Fruits and Vegetables Yesterday
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents.
• For this issue, respondents were asked to recall their food intake on the previous day.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

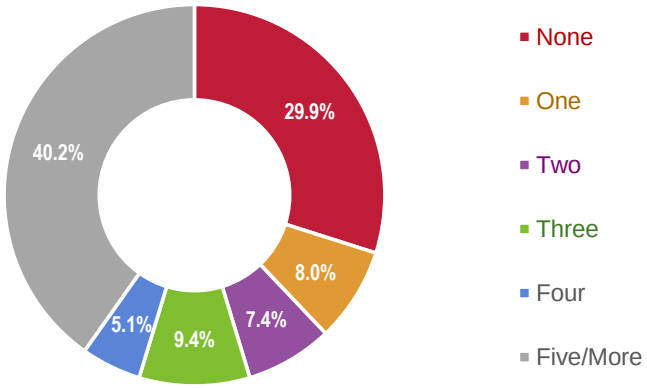
Family Meals

"How many meals per week does your entire household sit down together, without the television set on, for a family meal? Please include breakfasts, lunches, and dinners."

Among area households, 40.2% report eating at least five meals together as a family on a weekly basis.

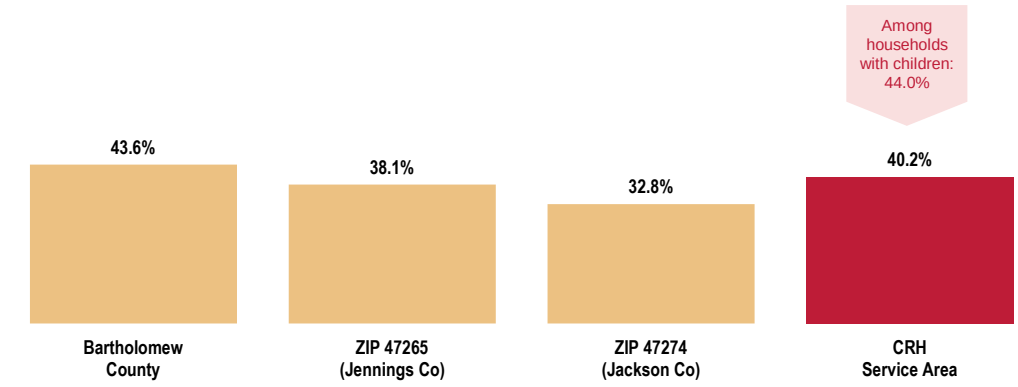
DISPARITY ► Those less likely to report eating meals as a family include adults younger than 65, lower-income households (especially), and Black or African American residents.

Number of Weekly Meals Shared as a Family
(CRH Service Area, 2024)



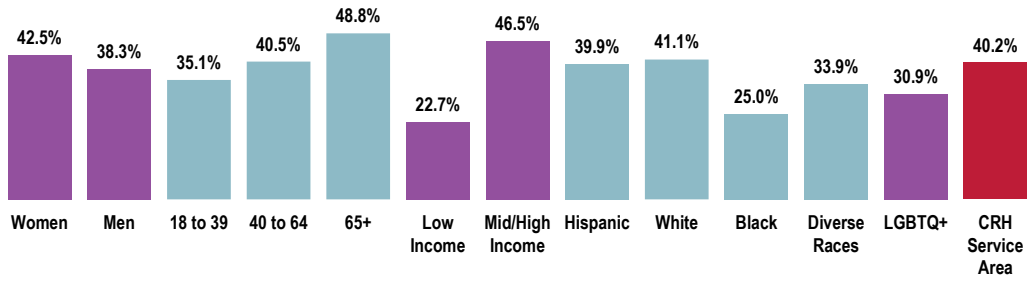
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: • Excludes respondents who live alone.
• Includes breakfasts, lunches, and dinners. Does not include meals during which the television is on.

Eat 5+ Weekly Meals Together as a Family



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 319, 345]
Notes: • Excludes respondents for whom the question does not apply.
• Includes breakfasts, lunches, and dinners. Does not include meals during which the television is on.

Eat 5+ Weekly Meals Together as a Family
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: • Excludes respondents for whom the question does not apply.
• Includes breakfasts, lunches, and dinners. Does not include meals during which the television is on.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

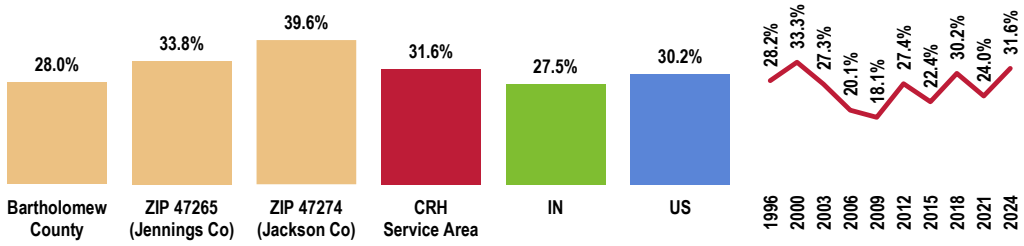
A total of 31.6% of Columbus Regional Health Service Area adults report no leisure-time physical activity in the past month.

BENCHMARK ► Higher than found statewide. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lowest in Bartholomew County.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

For adults, “meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activities:

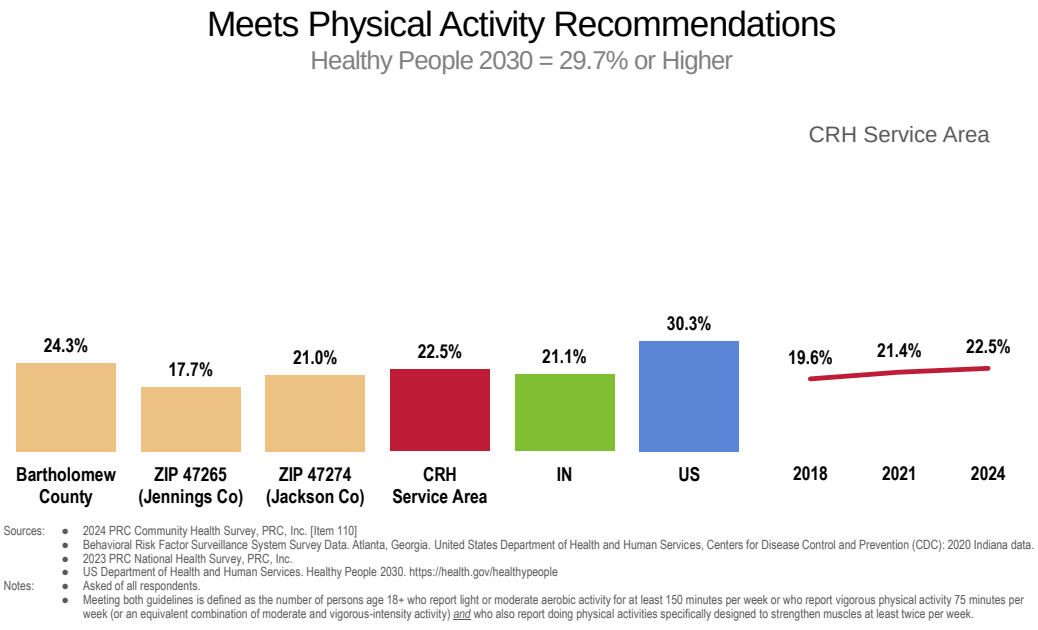
- **Aerobic activity** is one of the following: at least 150 minutes per week of light to moderate activity (such as walking), 75 minutes per week of vigorous activity (such as jogging), or an equivalent combination of both.
- **Strengthening activity** is at least two sessions per week of exercise designed to strengthen muscles (such as push-ups, sit-ups, or activities using resistance bands or weights).

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

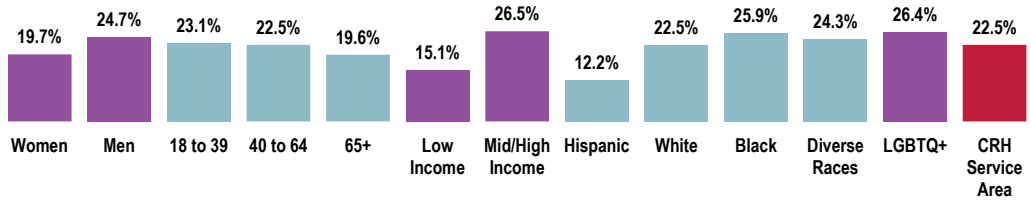
A total of 22.5% of Columbus Regional Health Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

BENCHMARK ► Lower than the US percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Less often reported among lower-income respondents and Hispanic residents.



Meets Physical Activity Recommendations
(CRH Service Area, 2024)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Children

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

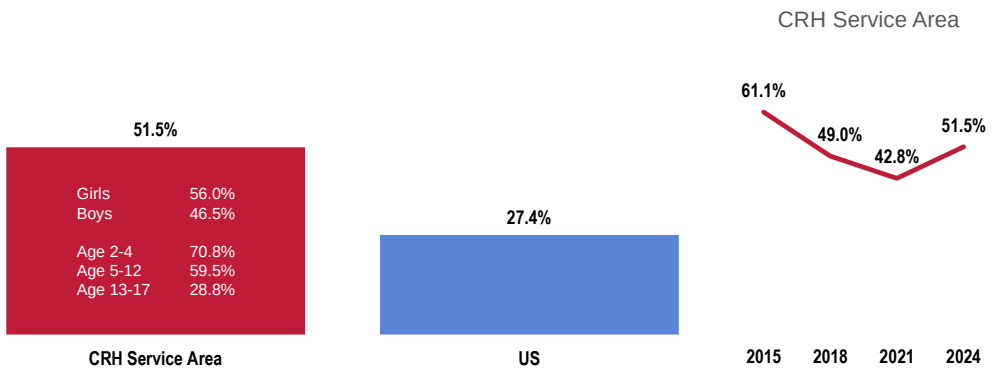
Among Columbus Regional Health Service Area children age 2 to 17, 51.5% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

BENCHMARK ► Much more favorable than the national finding.

TREND ► Represents a significant decrease from the 2015 baseline.

DISPARITY ► Boys and adolescents (age 13 to 17) are reported to be <u>less</u> active.

Child Is Physically Active for One or More Hours per Day
(CRH Service Area Children Age 2-17, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Screen Time

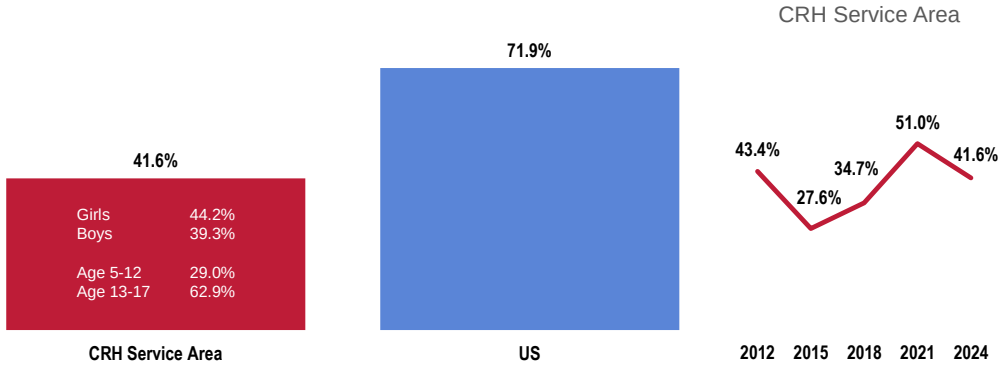
"During the school year, on an average school day, about how many hours or minutes does this child spend looking at a screen, such as watching TV, playing video games, using a computer, or using the internet for entertainment?"

Among service area children age 5 to 17, 41.6% are reported to spend three or more hours on screen time during a typical school day.

BENCHMARK ► Considerably lower than found nationally.

DISPARITY ► Higher among adolescents (age 13 to 17).

3+ Hours of Total Screen Time on School Days
(CRH Service Area Children Age 5-17, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 349]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.

Access to Physical Activity Facilities

Availability of Recreation & Fitness Facilities

In 2021, there were 11.5 recreation/fitness facilities for every 100,000 population in the Columbus Regional Health Service Area.

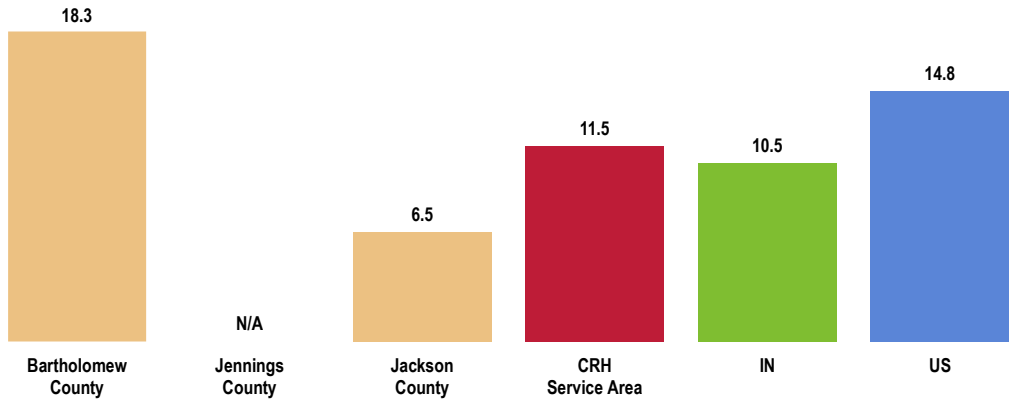
BENCHMARK ► Less favorable than found across the US.

DISPARITY ► Lower in Jackson County.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Number of Recreation & Fitness Facilities per 100,000 Population
(2021)



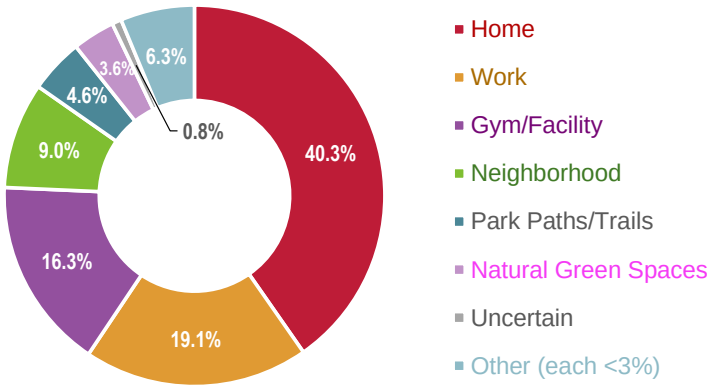
Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.*

Site of Most Physical Activity

Four in 10 service area respondents (40.3%) indicate that most of their physical exercise happens at home, followed by work (19.1%), or at a gym/fitness facility (9.0%).

Site of Most Physical Activity
(CRH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 320]

Notes:
- Asked of all respondents.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Overweight Status

Here, "overweight" includes those respondents with a BMI value ≥25.

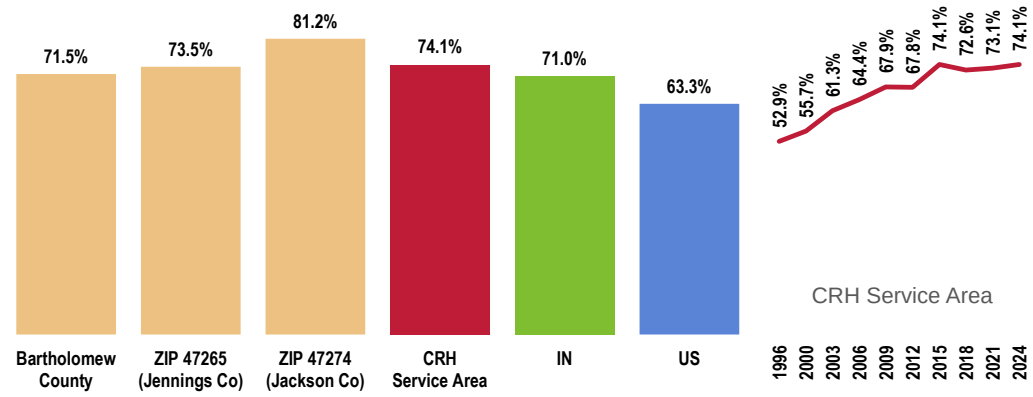
Nearly three-fourths Columbus Regional Health Service Area adults (74.1%) are overweight.

BENCHMARK ► Higher than found across the state and US.

TREND ► Rising significantly higher over time.

DISPARITY ► Highest in Jackson County ZIP Code 47274.

Prevalence of Total Overweight (Overweight and Obese)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0,. The definition for obesity is a BMI greater than or equal to 30.0.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

The overweight prevalence above includes 46.1% of Columbus Regional Health Service Area adults who are obese.

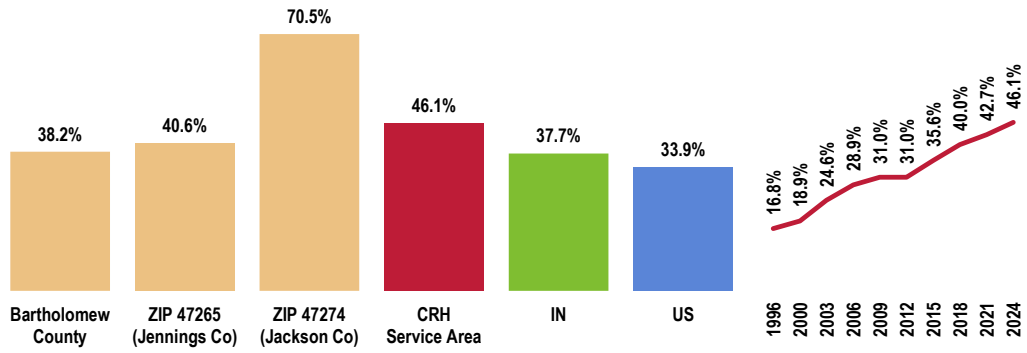
BENCHMARK ► Higher than found across the state and US. Fails to satisfy the Healthy People 2030 objective.

TREND ► Rising significantly higher over time.

DISPARITY ► Exceptionally high in Jackson County ZIP Code 47274. More often reported among adults age 40 to 64 and White respondents.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower



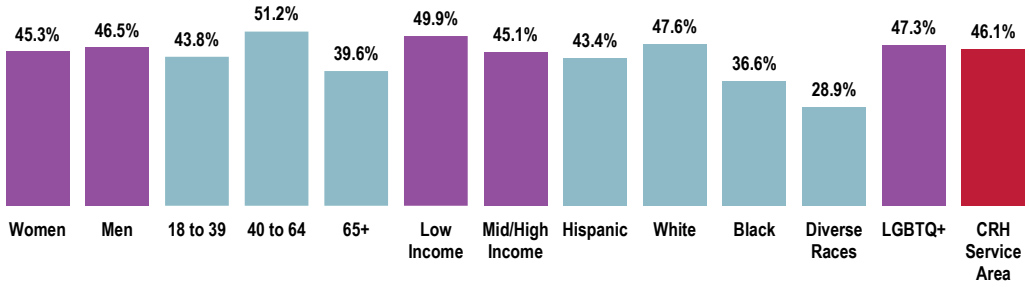
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Prevalence of Obesity

(CRH Service Area, 2024)

Healthy People 2030 = 36.0% or Lower



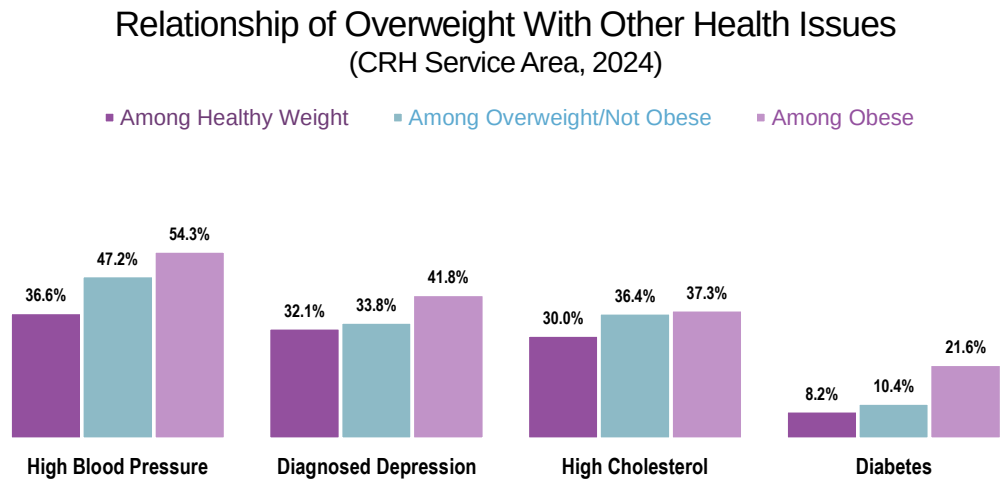
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Relationship of Overweight With Other Health Issues

The correlation between overweight and various health issues cannot be disputed.

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
Notes: ● Based on reported heights and weights, asked of all respondents.

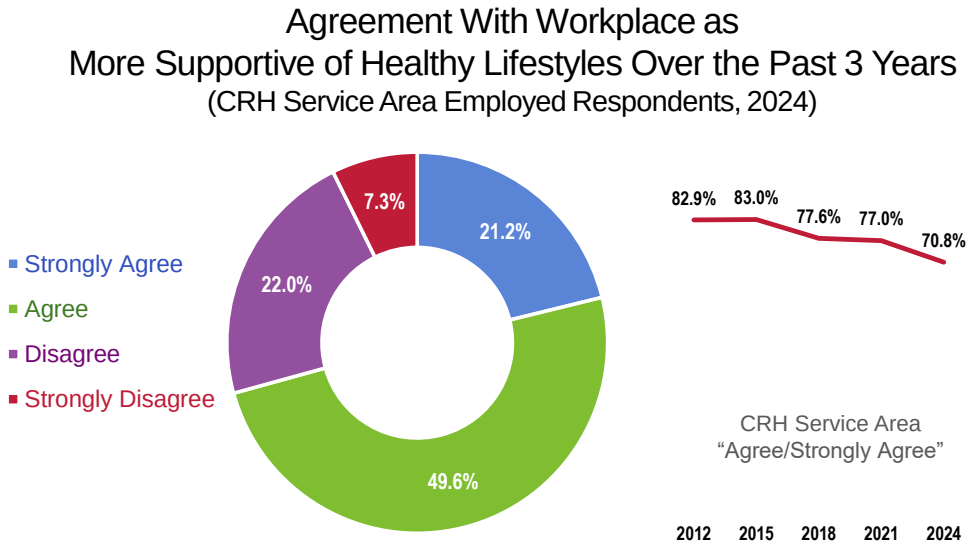
Workplace Support

"Please tell me your level of agreement or disagreement with the following statement: Over the past three years, my workplace has become more supportive of living a healthy lifestyle."

Among employed respondents, 7 in 10 (70.8%) agree that their workplace has become more supportive of a healthy lifestyle in recent years (giving "agree" or "strongly agree" responses).

TREND ► Marks a significant decline in agreement over time.

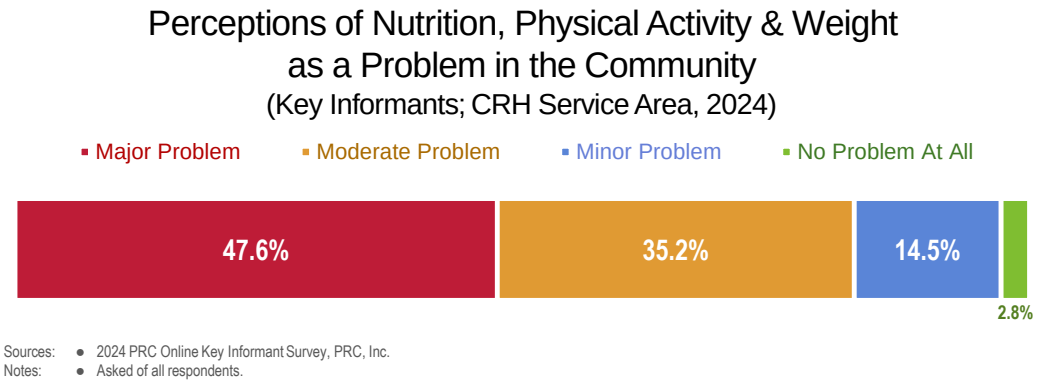
DISPARITY ► Lower-income adults are less likely to agree (not shown).



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 321]
Notes: ● Asked of all respondents who are currently employed.

Key Informant Input:
Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Lifestyle

Unhealthy eating habits, lack of exercise. – Community Leader

Too busy. Also, we need more social interaction-type programs to help keep people engaged in a program and stay on the program. When people try to work out on their own, they don't know what they are doing, get hurt, get frustrated, and then quit. – Community Leader

Changing lifestyles and habits is very hard, especially when the environment is designed to work against you. – Health Provider

Our society is moving away from personal connection, and we need that. Screens, easy access to unhealthy foods, and lack of movement are a serious problem. – Community Leader

Availability of food is not an issue. There are currently 4,000 calories per day per person available to every American. The issue is distribution and affordability. In addition, fewer people prepare their own food, which means that more people are eating in restaurants or are eating prepackaged meals. Obesity is often rooted in habits developed in childhood. People have become more sedentary, while physical activities and recess are less of a priority in elementary and high schools. The increase in screen time across the age span has exacerbated the problem. – Community Leader

Getting folks to eat and exercise for good health is an issue. – Community Leader

Stigma, lack of money to eat healthy and participate in physical activity. Education to eat healthy and physical activity. – Social Services Provider

Healthy diet, drinking, smoking, and lack of exercise. – Community Leader

Lack of access to nutritional foods, affordability, and people setting aside time to work out due to life events. – Health Provider

Access to healthy food and access to opportunities for physical activity. – Health Provider

Access to affordable nutritious food, lack of affordable exercise opportunities. – Health Provider

People in our community don't exercise enough or have good access to healthy food and knowledge about how to prepare it. Our community is designed mainly for vehicle travel, so most people drive even for short journeys, limiting their physical activity. In addition, good nutritious food is out of reach for many low-income community members due to its cost. Finally, even when people can afford healthy food, they often don't cook with it due to time constraints or lack of knowledge. – Health Provider

Lack of exercise and proper nutrition. – Community Leader

Sedentary lifestyles and social media. We have wonderful community facilities to stay active, but not enough people take advantage. – Community Leader

Lack of affordable fresh food, except for the summer farmer's market. Gym memberships are too expensive for many people. No low-cost or free gyms are available. – Community Leader

> Healthy food is expensive and can be more time-consuming to prepare. Time, money, and education. Self-care is not a priority when basic survival is the main focus. – Community Leader
>
> Unhealthy eating, lack of physical exercise, services available for low-income people related to healthy nutrition and foods. – Community Leader

Nutrition

> My comment reflects the status of food quality in America generally. The obesity rates in our country and the exponential problem this becomes for those living in poverty. These disparities are also increasingly represented in populations of color. – Community Leader
>
> Healthy eating, walkable access to services and work on mental and physical health, obesity. – Health Provider
>
> Unhealthy foods are cheap and easy and somehow more acceptable to eat. People don't use our parks to get everyday exercise. Too much screen time. – Health Provider
>
> Too much fast food and unhealthy eating establishments. Not enough good healthy food options. Cheaper to eat and drink junk than good nutritious foods. Processed foods being served in schools. WIC promoting things like juice for young babies and kids. – Physician
>
> Highly processed foods. Low nutritious foods. Soft drinks and other sugary beverages. – Community Leader
>
> There are a lot of obese people in this community, as in most of the Midwest. Sugar is the biggest problem. Cheap food has no nutritional value. Lack of education may contribute to this problem. – Public Health Representative
>
> Lack of a healthy diet. – Social Services Provider

Awareness/Education

> Having access to education with ongoing individual and community support. – Community Leader
>
> Lack of cooking and life skills/education. High cost of healthy prepared foods. Difficulty transporting food or paying for delivery fees for those without transportation and/or mobility issues. Long work hours required for basic survival do not allow time for recreation. Ubiquitous marketing of ultra-processed foods and acceptance of these foods as the “standard,” especially in school meals and incentives. – Health Provider
>
> Education about nutrition. Access to healthy foods that are affordable. – Physician
>
> Uneducated and low-income. – Community Leader
>
> Lack of knowledge about the importance of nutrition, physical activity, and weight. Social drivers of health, such as poverty and health literacy, may impact the ability to exercise and afford healthy foods. – Physician
>
> Weight loss programs. – Health Provider
>
> Lack of education and understanding of proper nutrition. – Health Provider
>
> More education on nutrition provided by employers also needs to permit employees to get physical activity while at work. – Community Leader

Obesity

> Obesity. – Community Leader
>
> Columbus is very much a typical community in regard to obesity, fast food chains, etc. We provide subpar food offerings for school lunches to our economically disadvantaged children because it’s the cheapest option. We have the ability and potential to be much more impactful than we currently are. – Community Leader
>
> Obesity rate. – Health Provider
>
> Obesity and diabetes are issues. – Community Leader
>
> Our society has major issues of obesity. – Community Leader
>
> Overweight is not being addressed by physicians until a major medical problem occurs. Need to get the weight off prior to major medical issues. – Health Provider
>
> People are overweight and sedentary. – Health Provider

Access to Care/Services

> People don’t have access to specialized resources to lose weight. – Health Provider
>
> Lack of wellness programs within the community and through employers. – Community Leader
>
> Programs. – Social Services Provider
>
> Lack of nutritionists, dieticians, and healthy restaurant options. – Community Leader

Income/Poverty

> Where do we start unpacking this question?! Socioeconomics. Poor people do not have the same access to high-quality foods: Starches and sugary sodas are the cheapest foods. Time: Good nutrition takes considerably more time than opening a bag of chips. Time: If you are working long hours or two jobs to make ends meet, raising kids, etc., self-care and nutrition are secondary considerations. Weather: unpleasant in the winter, hot and humid in the summer. Local topography: While there are agricultural runoff rivers, there is no public access to lakes/beaches, mountains/wilderness to encourage getting out and participating in the outdoors. Cornfields are not that much fun. – Community Leader
>
> Low-income families in particular do not have the same opportunities. Rising inflation costs make healthier options unaffordable. – Community Leader
>
> Mental health, financial insecurity, insurance do not cover the most important parts of keeping people healthy: exercise programs or PT for obesity, nutrition classes for families and older people. Affordable, healthy options are hard to come by. – Physician

Affordable Care/Services

> Affordability, access, and lifestyle, habits and needs to work and manage life. – Community Leader
>
> Resources for low-income households. Rise in prices and people being able to afford it. – Social Services Provider
>
> More free services or at low cost. – Health Provider

Diagnosis/Treatment

> Doctors push medicines down people's throats. Oh, you're fat, here's a script for Ozempic. Instead of telling them to cut out processed foods and get off their tails and move. But once again, there's no profit in a healthy community. – Community Leader
>
> I don't think this issue applies to B. Co. only. In general, we are on a hamster wheel. Individuals injure themselves and don't seek medical care. These injuries limit mobility, which leads to obesity. Obesity leads to mobility issues. We don't have a lot of healthy food options (restaurants) in our community. Of the three areas, I think we have the greatest access to physical activity with robust offerings by Parks & Rec, FFY, etc. We also have the People Trail that a lot of communities do not have. – Community Leader

Access to Affordable Healthy Food

> Access to healthy foods, healthy habits education, and the cost. – Health Provider
>
> Low access to affordable healthy foods. – Physician

Social Determinants of Health

> Social determinants of health are an ongoing barrier to time. – Health Provider
>
> Social determinants of health in Columbus – Social norms that don't support a healthy lifestyle, lack of family support, lack of healthy options for food, lack of well-being prioritization in comparison to basic needs, need for more health literacy/education. – Health Provider

Cultural/Personal Beliefs

> This is more of a cultural concern. Not great food options. Lack of healthy restaurants. – Community Leader

Prevention

> Not enough people make a proactive effort to keep themselves healthy. Not enough emphasis on preventive measures when it comes to proper exercise and diet. – Community Leader

Follow Up/Support

> Support for the ability to change their lifestyle to have better nutrition and increase physical activity. – Community Leader

Lack of Providers

> No nutritionist specialist to refer patients to. – Physician

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

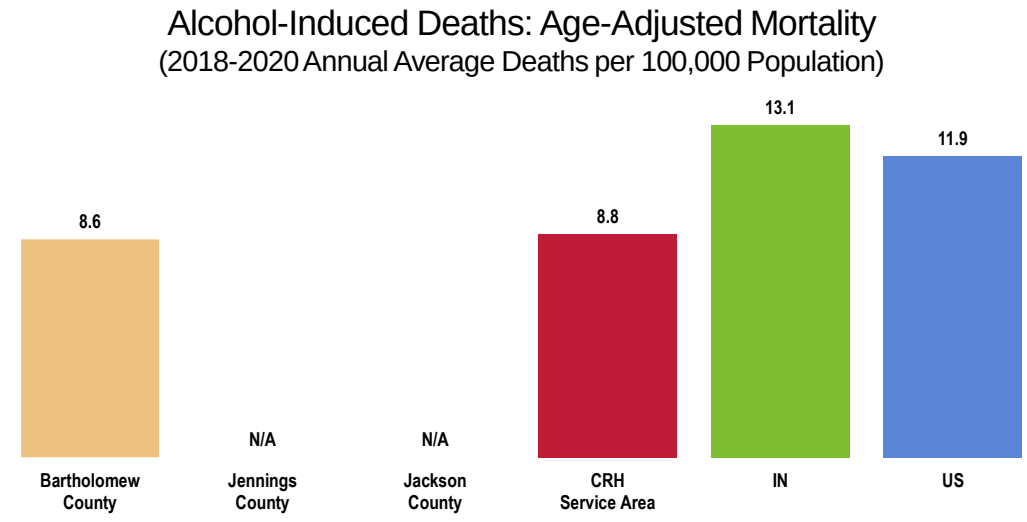
– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol Use

Age-Adjusted Alcohol-Induced Deaths

Between 2018 and 2020, the Columbus Regional Health Service Area reported an annual average age-adjusted mortality rate of 8.8 alcohol-induced deaths per 100,000 population.

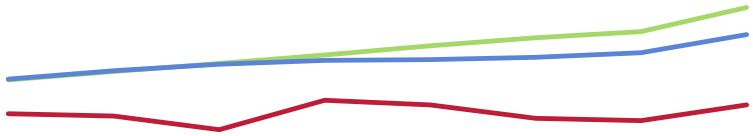
BENCHMARK ► Lower than state and US findings.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Alcohol-Induced Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	8.4	8.3	7.7	9.0	8.8	8.2	8.1	8.8
IN	9.9	10.3	10.6	11.0	11.4	11.8	12.0	13.1
US	9.9	10.3	10.6	10.8	10.8	10.9	11.1	11.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

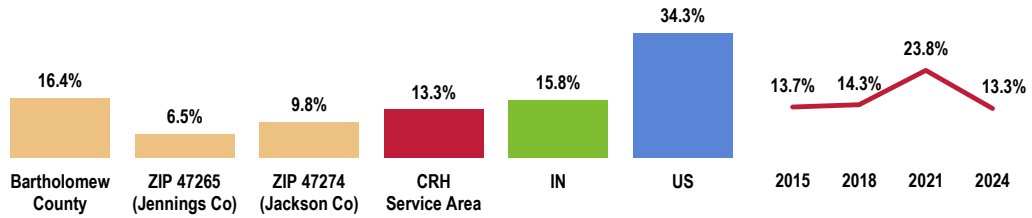
A total of 13.3% of area adults engage in excessive drinking (heavy and/or binge drinking).

BENCHMARK ► Lower than found across Indiana and considerably lower than found across the US.

DISPARITY ► Highest in Bartholomew County. More often reported among adults younger than 65, those with higher incomes, and non-Hispanic residents.

Engage in Excessive Drinking

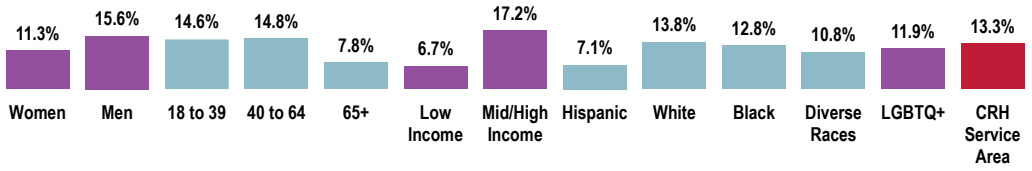
CRH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Engage in Excessive Drinking
(CRH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Drug Use

Age-Adjusted Unintentional Drug-Induced Deaths

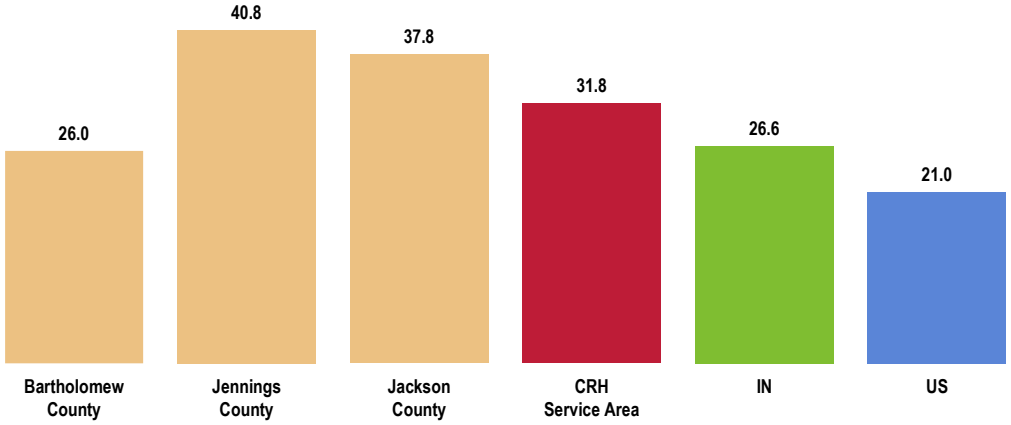
Between 2018 and 2020, there was an annual average age-adjusted mortality rate of 31.8 unintentional drug-induced deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Higher than the Indiana and US rates.

TREND ► Rising significantly within the service area over time.

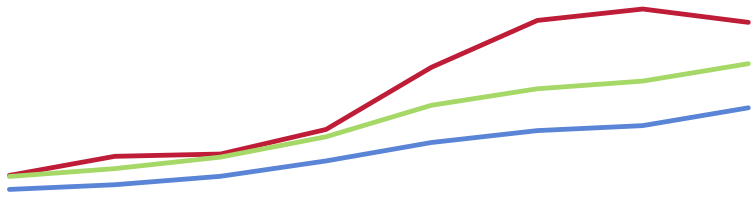
DISPARITY ► Lowest in Bartholomew County.

Unintentional Drug-Induced Deaths: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

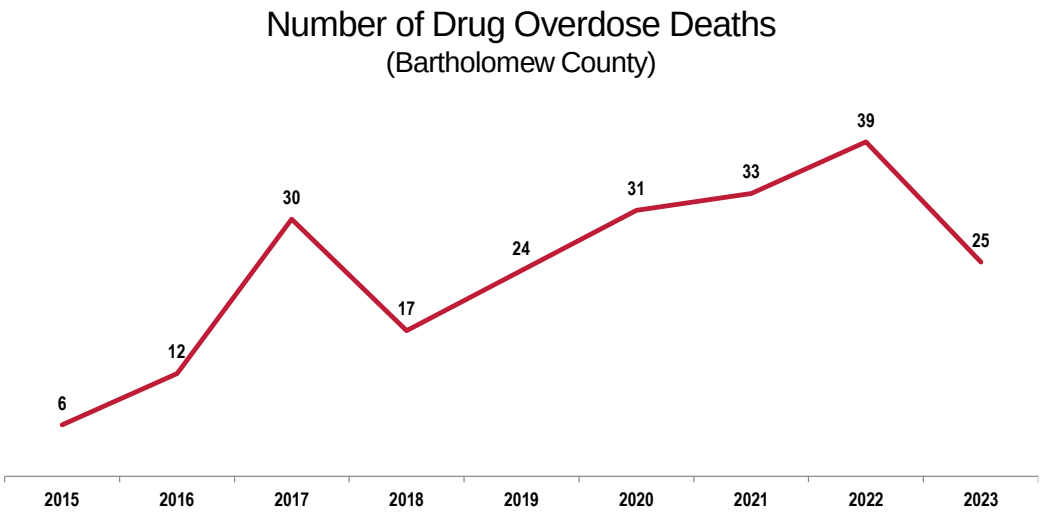
Unintentional Drug-Induced Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
CRH Service Area	12.5	14.9	15.2	18.3	26.1	32.1	33.5	31.8
IN	12.4	13.4	14.8	17.4	21.4	23.4	24.4	26.6
US	10.7	11.3	12.4	14.3	16.7	18.1	18.8	21.0

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Counts for drug overdose deaths Bartholomew County between 2015 and 2023 are shown below.



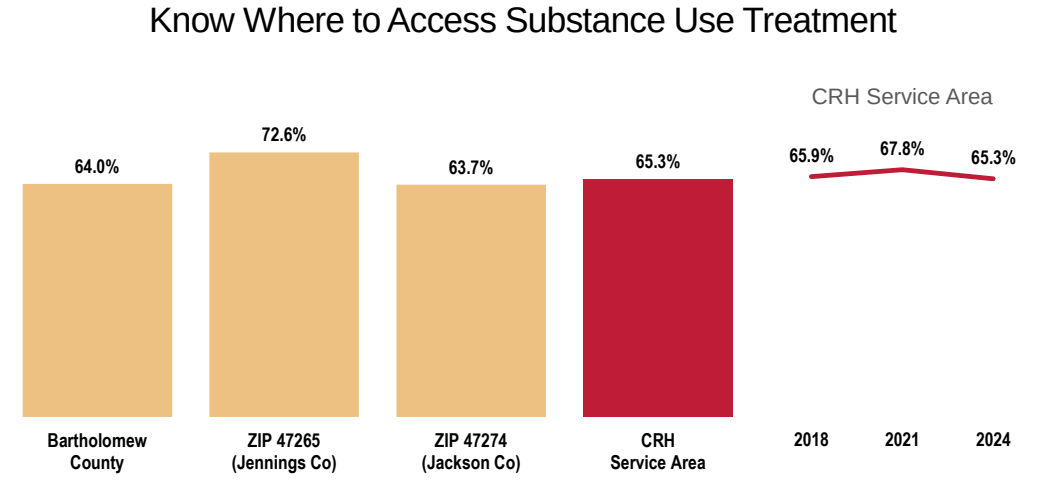
Sources: ● Source: Bartholomew County Coroner's Office https://bartholomew.in.gov/county-coroner.html#annual-report

Alcohol & Drug Treatment

Awareness of Services

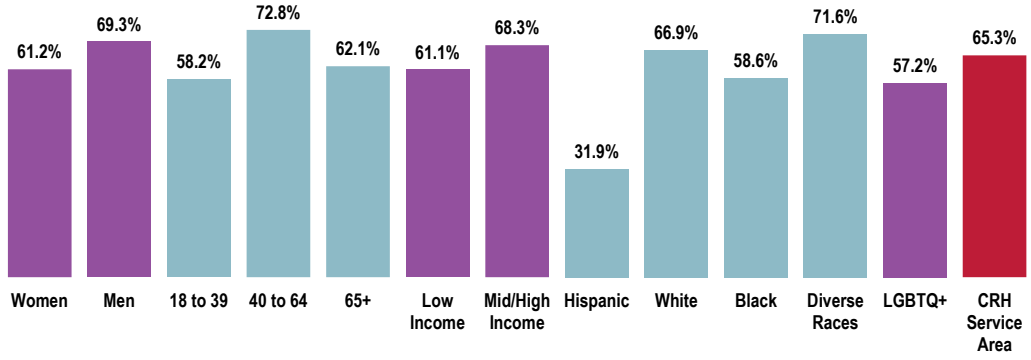
Two-thirds of service area residents (65.3%) report that they know where to access alcohol- or drug-related services if they needed treatment.

DISPARITY ► Those less likely to express awareness of services include women, adults age 18 to 39, adults age 65+, and those with lower incomes. Awareness is exceptionally low among Hispanic respondents.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.
● Beginning in 2021, respondents were asked about alcohol-related treatment in addition to drug-related treatment.

Know Where to Access Substance Use Treatment
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

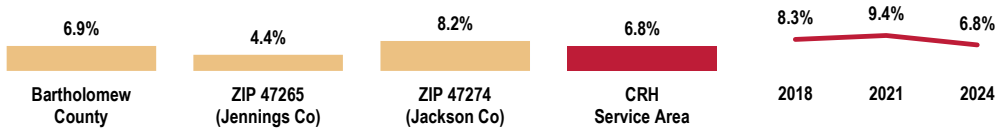
Difficulty Accessing Services

Of the total sample of survey respondents, 6.8% acknowledge a time in the past year when they or a family member needed professional help for an addiction but were unable to get it.

DISPARITY ► More often reported among women, adults younger than 65, and those with lower incomes.

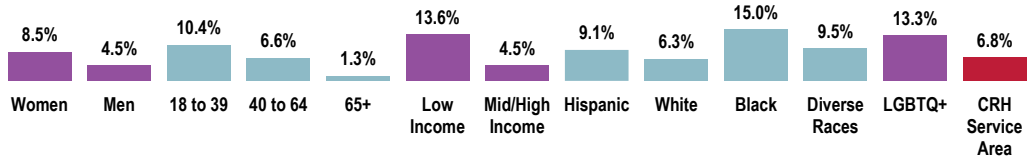
Family Member Was Unable to Access Professional Help for an Addiction in the Past Year

CRH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: ● Asked of all respondents.

Family Member Was Unable to Access Professional Help for an Addiction in the Past Year
(CRH Service Area, 2024)



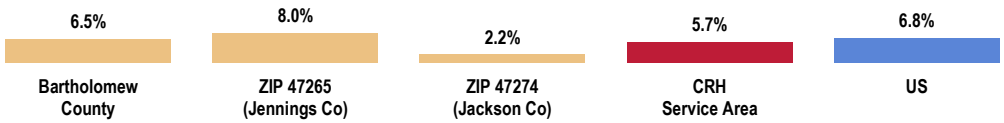
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: • Asked of all respondents.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Ever Sought Help for Substance Use Issues

A total of 5.7% of Columbus Regional Health Service Area adults report that they have sought professional help for themselves for an alcohol or drug problem at some point in their lives.

DISPARITY ► Lowest in Jackson County ZIP Code 47274.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

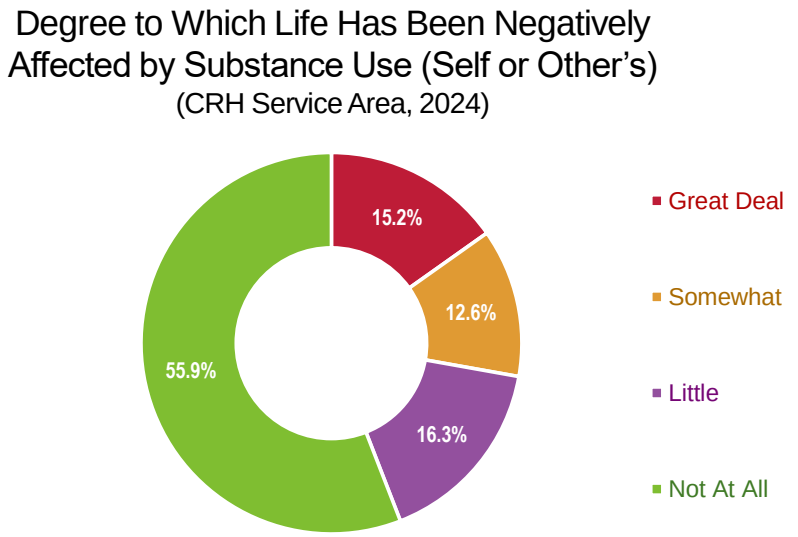


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 42]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Personal Impact From Substance Use

Surveyed adults were also asked to what degree their lives have been impacted by substance use (whether their own use or that of another).

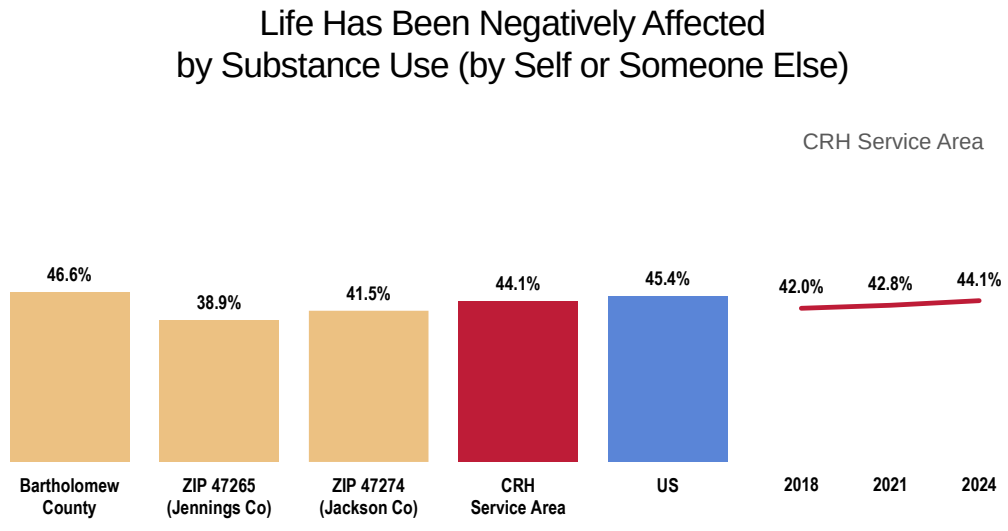
Most Columbus Regional Health Service Area residents' lives have <u>not</u> been negatively affected by substance use (either their own or someone else's).



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
Notes: • Asked of all respondents.

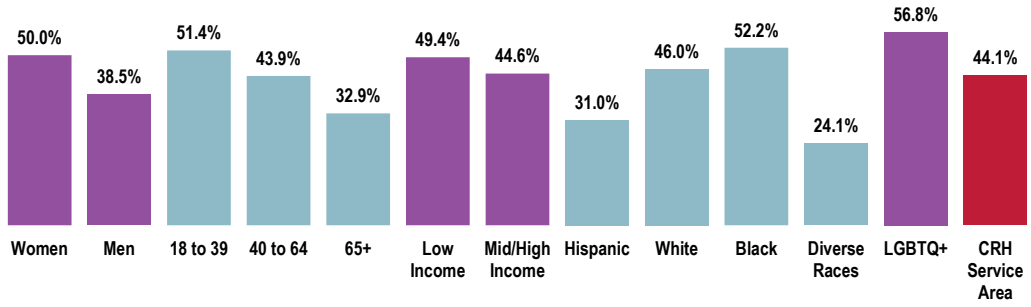
However, 44.1% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

DISPARITY ► More often reported among women, adults younger than 65, White residents, Black or African American residents, and LGBTQ+ respondents.



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes those responding "a great deal," "somewhat," or "a little."

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(CRH Service Area, 2024)



Sources: 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
Notes:
- Asked of all respondents.
- Includes those responding "a great deal," "somewhat," or "a little."
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Key Informant Input: Substance Use

A high percentage of key informants taking part in an online survey characterized *Substance Use* as a "major problem" in the community.

Perceptions of Substance Use as a Problem in the Community
(Key Informants; CRH Service Area, 2024)

Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Bartholomew County has good after-treatment resources. For a good treatment facility, one needs to go outside Bartholomew County. – Social Services Provider
>
> Residential rehab facilities. – Community Leader
>
> Limited inpatient treatment options. Funding for programs. – Public Health Representative
>
> Inpatient treatment center. – Public Health Representative
>
> This is much improved. Would like to see more focus on easy and barrier-free support or treatment for those still in active substance use. – Health Provider
>
> Resources and education. – Health Provider
>
> Access to mental health care and social determinants of health. Stigma. – Community Leader
>
> We have plenty of sober living homes and outpatient treatment. However, when people need inpatient treatment, we don't have a ton of options here. – Community Leader

The issues are so prevalent, I think there is a lack of nearby facilities open during needed hours. – Community Leader

Connecting the person with the need to the service at the time when they are most ready to address their need. It doesn't always happen 8 a.m. to 5 p.m., Monday through Friday. – Community Leader

Availability to providers treating substance use, and transportation. – Community Leader

Availability and unwillingness to get care. – Community Leader

Access, resources, cost of treatment, stigma, lack of need recognition in the individual, and social support at home. – Health Provider

Timely access and robust prevention efforts. – Health Provider

Access, availability, and transportation. Not sure about detox. – Health Provider

Resources for substance abuse treatment. – Community Leader

Awareness/Education

Education – trying to reach everyone in the community where they can go to get help. For example, I do not have a substance abuse problem – however, I do know there are programs out there to help me if I did. However, I do not know where those programs are located or the first step to gain access to those programs. I feel I'm in a better position by knowing about them … however, If I were the one having the issue and not knowing where to go, would likely prevent me from trying to ask or seek them out because I wouldn't want to admit to anyone outside the program that I have an issue. – Community Leader

The community knowing where to go and understanding the costs, especially if they are underinsured. – Health Provider

Families need to know the pathways, as the client may not be able to seek this information. Businesses need to know how to include the family members to see a more accurate view than the individual in need may be able to provide. Help for the individual who is suffering from substance use needs some form of checklist to see what help they need. – Community Leader

In my opinion, Columbus has many options for those needing substance abuse assistance, but most of these individuals do not know about them or know how to locate the services. – Public Health Representative

Education. – Community Leader

Easily obtained without early education. – Community Leader

Access to treatment and care has improved. Perhaps more emphasis on underlying causes. – Community Leader

Lack of education, perhaps facilities. – Community Leader

Awareness and access to resources, such as transportation, insurance, and family/friend support. – Health Provider

Awareness of available services by those who abuse. – Community Leader

Lack of knowledge of resources and contacts. – Community Leader

Desire to Stop Use

Willingness, and perhaps knowledge. – Health Provider

Lack of desire to make changes, loss of social network and friendships if help is sought, and dependence issues. – Community Leader

People have got to want to change. We cannot make people stop doing something they take pleasure in or do to escape reality. Maybe it's a mental health issue. People need to be productive to feel worth. – Public Health Representative

I think the resources are there, but people have to want to seek them out. I feel the community has done a good job of offering resources, but you can't make people use them if they are not ready and willing to use them. – Social Services Provider

Willingness of the individual to change and access resources. – Community Leader

Willingness, ease of access to drugs and alcohol, helping recovering folks find meaning in life and showing them clean and sober is a better way to live. – Community Leader

In most cases, getting the user in the right state of mind to seek or accept help and knowing where to go. – Public Health Representative

Lack of readiness in the person in active addiction. Lack of awareness of available resources. Transportation. – Community Leader

Readiness and willingness to get treatment. Comorbid mental health disorders. – Physician

Unwilling to get help needed. – Community Leader

Denial/Stigma

> It's gotten better over the years since ASAP, but the stigma behind it is the greatest barrier. Followed by resources to pay for treatment. – Community Leader
>
> Stigmas and access to care. – Social Services Provider
>
> Stigma. – Physician
>
> Substance abuse aid feels like it is taboo, and we have lots of participants that are having this issue and unable to receive services due to previous treatment or lack of insurance covering it. – Social Services Provider
>
> Stigma, education, and transportation. Lack of understanding about alcohol as a drug, put it as legal. – Social Services Provider
>
> The stigma surrounding substance use is still a significant barrier. Also, the cost of treatment and time needed to get help may prevent some from seeking it. – Health Provider
>
> I suspect the greatest barrier is that those with issues are denying the existence of a problem, and therefore are not taking the first steps toward treatment. – Health Provider
>
> Stigma. – Health Provider
>
> Acceptance as a disease by the public. – Community Leader

Affordable Care/Services

> Cost, stigma, continued support post-treatment, poverty, access to health care, family problems, lack of parenting, honestly don't know of any substance treatment facilities in Columbus, teens don't have access for support. They only have consequences at school and no access to help them actually work through the addiction. Maybe an online class. – Community Leader
>
> Resources are not affordable. – Social Services Provider
>
> Lack of affordable recovery care, lack of supportive housing for those in recovery. – Community Leader
>
> It has improved but lacks affordable inpatient and outpatient treatment. – Community Leader

Lack of Providers

> The paucity of psychiatric providers. – Physician
>
> Low ratio of providers to clients. Transportation outside of the city of Columbus. Lack of reliable transportation in rural areas. – Health Provider
>
> While Columbus and Bartholomew County have made very significant improvements in this area, facilities, staff, and funding remain a challenge. – Community Leader

Transportation

> Transportation and consistency. – Community Leader
>
> Transportation, willingness to admit there is a problem, stigma attached to substance use, and fear of losing a child to DCS. – Health Provider
>
> Transportation. – Health Provider

Diagnosis/Treatment

> I do know barriers in other places I've been are a lack of holistic treatment for substance use. In other words, treating addiction is more than just dealing with the chemical dependency itself. It's opening opportunities for people to find jobs, learn how to manage finances, and also learn how to build healthy relationships. – Social Services Provider
>
> Meth not having clear treatment options. – Health Provider

Incidence/Prevalence

> Being dealt with much better. The biggest problem is simply the seriousness of the disease and the availability of products of abuse. – Physician
>
> We have made great strides in this area since the formation of ASAP. However, great strides with a gigantic problem still leaves us with a major problem. It seems, in particular, we continue to struggle with incarcerated individuals and their return to society. – Community Leader

Insurance Issues

> Lack of national guidelines to prevent denials for services, health coverage, financial burden, transportation and stigma. – Health Provider
>
> Insurance, transportation, education. – Social Services Provider

Alcohol/Drug Use

> I think the work our community is doing and has done is incredible. The problem remains and I believe it is due, in part, to self-medication for other problems. – Community Leader Cultural/Personal Beliefs

Follow Up/Support

> Accountability and follow-up while one is in recovery. There are several resources for substance use treatment in the community, but some of these treatments are only available during business hours, and there isn't access to after-hours treatments for substance use. – Community Leader

Cultural/Personal Beliefs

> They need more Jesus and less legal drugs. – Community Leader

Government/Policy

> Lack of financial support by the state government. – Community Leader

Vulnerable Populations

> With the Stride Center and all of the homeless in this community, we are seeing a rise in opioid and meth use. Other communities are exporting their issues into our community, and it was severely underestimated how many homeless Stride would bring in and an utter lack of resources available. Now we have homeless begging on every intersection on 31 from 25th to Taylor. – Community Leader

Income/Poverty

> Financial limitations and capacity within our community. – Community Leader

Prevention/Screenings

> I think the treatment is there now. Just wish there was more we could do for prevention and getting people ready to get treatment. – Physician

Racism

> Racial equality. – Community Leader

Social Norms/Community Attitude

> The substance abuse is more common and society has accepted it, but don’t have prevention, only at schools. – Health Provider

Most Problematic Substances

Key informants (who rated this as a “major problem”) identified **methamphetamine/other amphetamines heroin/other opioids**, and **alcohol** as causing the most problems in the community.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Key Informants Rating Substance Use as a “Major Problem”)	
METHAMPHETAMINE OR OTHER AMPHETAMINES	27.3%
HEROIN OR OTHER OPIOIDS	26.9%
ALCOHOL	23.9%
PRESCRIPTION MEDICATIONS	7.1%
MARIJUANA	5.0%
COCAINE OR CRACK	4.6%
SYNTHETIC DRUGS (e.g. Bath Salts, K2/Spice)	2.1%
INHALANTS	1.3%
OVER-THE-COUNTER MEDICATIONS	0.8%
CLUB DRUGS (e.g. MDMA, GHB, Ecstasy, Molly)	0.5%
HALLUCINOGENS OR DISSOCIATIVE DRUGS (e.g. Ketamine, PCP, LSD, DXM)	0.5%

TOBACCO USE

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

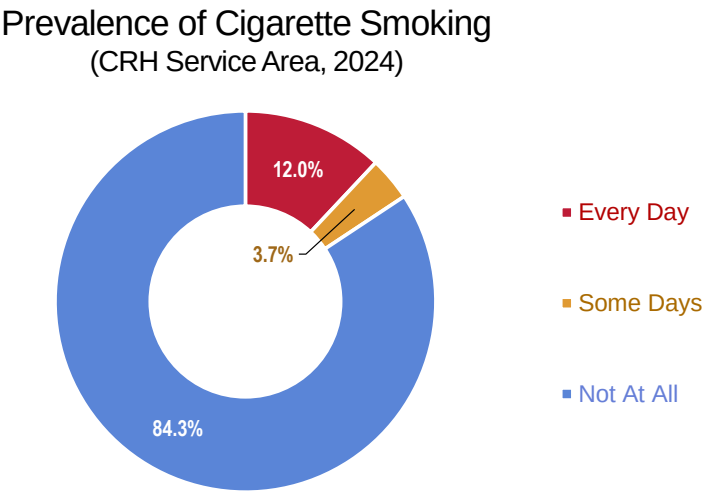
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

Prevalence of Cigarette Smoking

A total of 15.7% of Columbus Regional Health Service Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: • Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the Columbus Regional Health Service Area.

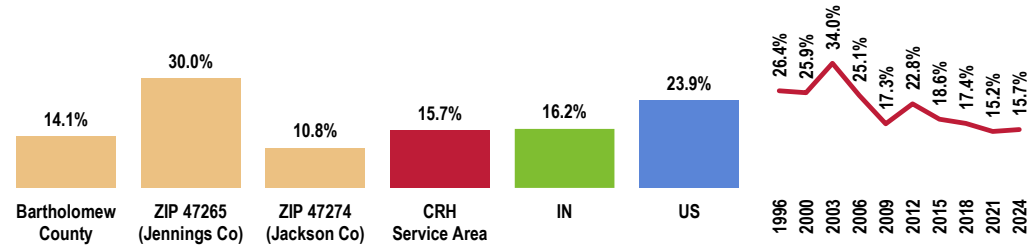
BENCHMARK ► Lower than found nationally. Fails to satisfy the Healthy People 2030 objective.

TREND ► Marks a significant decline over time.

DISPARITY ► Highest in Jennings County ZIP Code 47265. Adults age 40 to 64 and especially those with lower incomes are more likely to report that they smoke cigarettes.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower



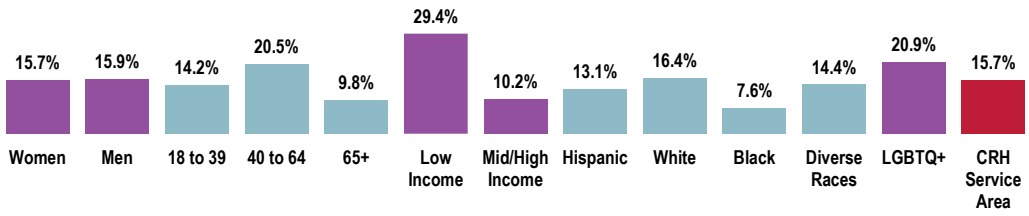
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Currently Smoke Cigarettes

(CRH Service Area, 2024)

Healthy People 2030 = 6.1% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Environmental Tobacco Smoke

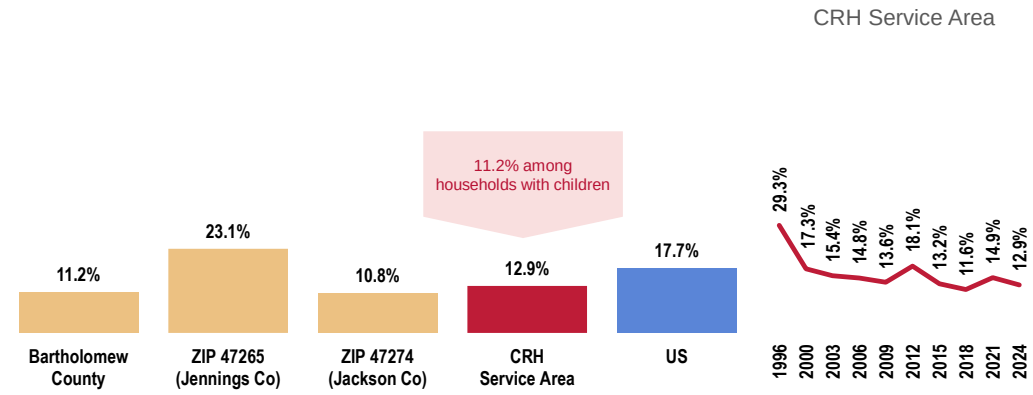
Among all surveyed households in the Columbus Regional Health Service Area, 12.9% report that someone has smoked cigarettes, cigars, or pipes anywhere in their home an average of four or more times per week over the past month.

BENCHMARK ► Lower than the US percentage.

TREND ► Represents a significant decline over time.

DISPARITY ► Highest in Jennings County ZIP Code 47265.

Member of Household Smokes at Home



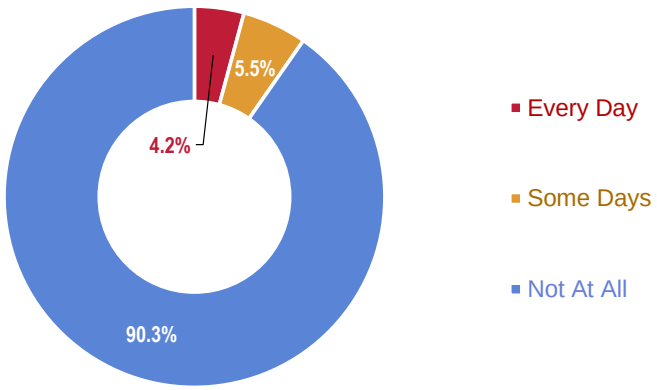
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Use of Vaping Products

Most Columbus Regional Health Service Area adults do not use electronic vaping products.

Use of Vaping Products
(CRH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]

Notes:
- Asked of all respondents.

However, 9.7% currently use electronic vaping products either regularly (every day) or occasionally (on some days).

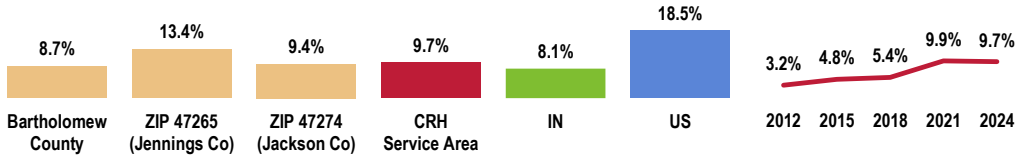
BENCHMARK ► About half the national percentage.

TREND ► Marks a significant increase over time.

DISPARITY ► Women, adults younger than 65 (especially those age 18 to 39), lower-income residents, and LGBTQ+ respondents are more likely to report that they use vaping products.

Currently Use Vaping Products
(Every Day or on Some Days)

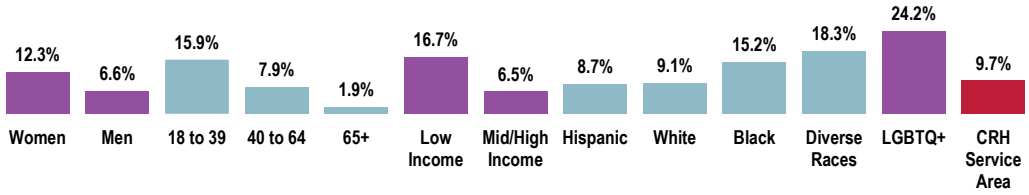
CRH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Currently Use Vaping Products
(CRH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

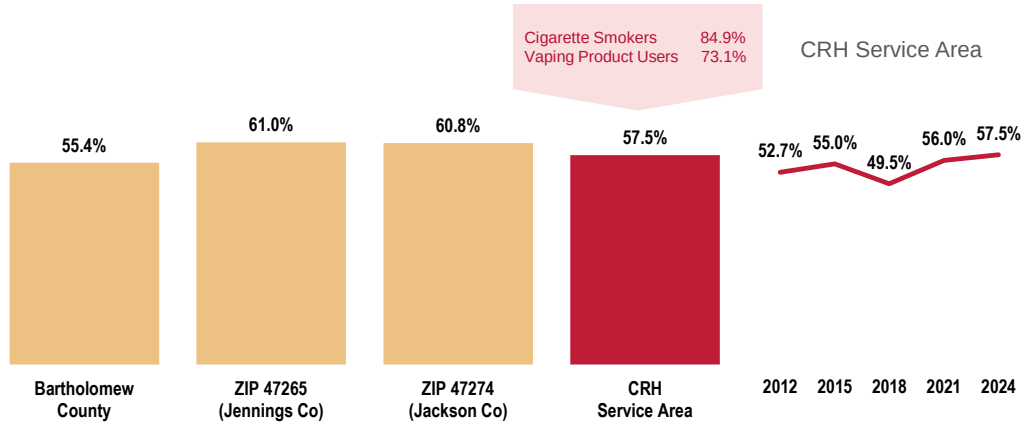
Awareness of the Indiana Tobacco Quit Line

More than one-half of survey respondents (57.5%) are aware of the Indiana Tobacco Quit Line (1-800-QUIT-NOW).

TREND ► Rising significantly higher over time.

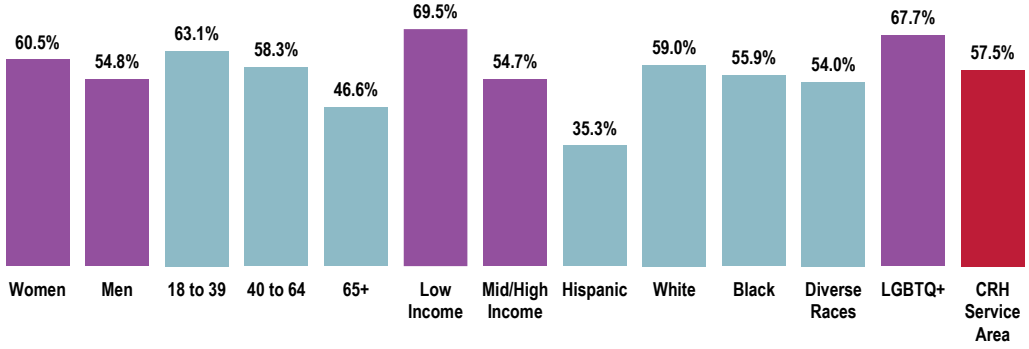
DISPARITY ► Awareness of the quit line is lower among adults age 65+, those with higher incomes, and Hispanic residents. Meanwhile, awareness is higher among those with lower incomes and LGBTQ+ respondents (as well as among those who current smoke or vape).

Aware of the Indiana Tobacco Quit Line: 1-800-QUIT-NOW



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: ● Asked of all respondents.

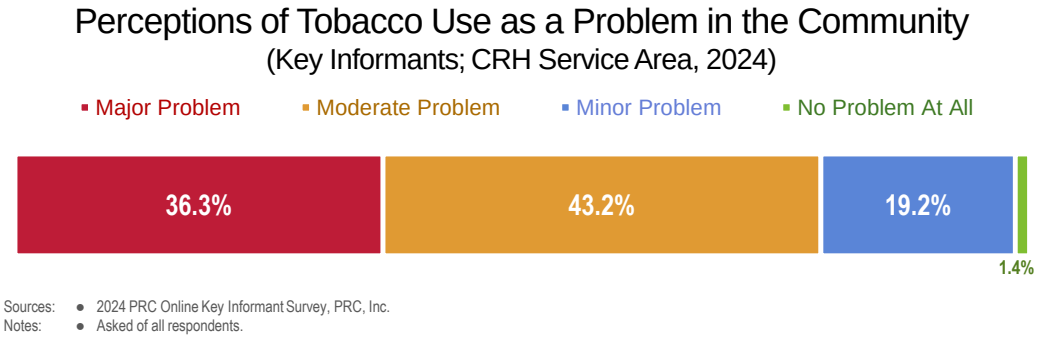
Aware of the Indiana Tobacco Quit Line: 1-800-QUIT-NOW
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Key Informant Input: Tobacco Use

Key informants taking part in an online survey generally characterized *Tobacco Use* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

High proportion of caregivers that I meet are smokers. – Physician

Tobacco use remains a significant public health issue due to its widespread impact on individuals and communities in the several areas, including: various serious health issues, including lung cancer, other cancers, heart disease, stroke, and chronic respiratory diseases. Economic costs – high health care costs for treating diseases caused by smoking and lost productivity due to sickness and premature death. Addiction: Nicotine in tobacco products is highly addictive. Impact on youth: The initiation of tobacco use is typically during adolescence. Early exposure to nicotine can lead to lifelong addiction, and the younger someone starts smoking, the more likely they are to continue smoking into adulthood. Social inequalities: Tobacco use is often higher among certain populations, such as those with lower income and education levels. Environmental impact: Tobacco cultivation and the production, distribution, and disposal of tobacco products have significant environmental impacts. – Community Leader

I see a lot of people smoking cigarettes and vaping. – Community Leader

Tabacco use is still a health and financial issue for (estimated) 20% to 30% of our smoker/snuff/vaping users in our population. Smoking makes users and other family members more prone to heart and lung diseases, shortens their lives, and affects other people living with the smokers. The expense of smoking/dipping/vaping reduces the available money that affects buying healthy food and or other items for a better lifestyle. – Community Leader

Smoking and vaping rate for adults and teens is over 20%. High rate for pregnant women. – Health Provider

Indiana is known to have a very high rate of tobacco use when compared to other US states. The most recent statistics I have seen show that greater than 20% of adults in Bartholomew County smoke, which is even higher than the statewide average, which is around 19%. – Physician

Statistics consistently show that use rates are too high here, and tobacco use causes significant health issues. – Health Provider

Smoking incidence is high, low utilization of cessation resources. – Health Provider

People are still smoking and using smokeless tobacco. The vaping epidemic. – Community Leader

Smoking rates are high, and vaping rates are awful. – Health Provider

There are many people that continue to smoke despite the warnings of the hazards of smoking. – Community Leader

Continued use. – Health Provider

E-Cigarettes

High rate of smoking and vaping. High rate of teenagers vaping. – Physician

More young people start vaping. – Health Provider

Kids are using vapes at an all-time high. – Community Leader

See people vaping and look at all the stores offering tobacco products. – Health Provider

Vaping and the flavors, targeted at children. – Public Health Representative

> I believe we have a growing population of young people who think smoking and vaping is okay and safe. – Social Services Provider
>
> Vaping for teens and smoking for other people. – Health Provider
>
> Vaping has caused the issue to be large in our community, particularly with youth. – Community Leader

Impact on Quality of Life

> Tobacco is known to cause cancer. – Social Services Provider
>
> Tobacco uses eventually leads to mortality and morbidity that could be avoided. – Community Leader
>
> High cancer and cardiovascular disease. – Health Provider
>
> Leads to a lot of health-related problems, and still too many people smoking. Also, so many kids vaping and using and being exposed to other drugs through vaping. – Physician
>
> Poor health outcomes. – Community Leader

Lifestyle

> Frequently used as a coping mechanism. – Social Services Provider
>
> Habits. – Community Leader

Teen/Young Adult Usage

> It is designed to be attractive to young people to be cool. – Community Leader
>
> You see a lot of people, including young people, smoking. – Social Services Provider

Social Norms/Community Attitude

> Social norms that support smoking. Prevalence in the community and in families makes it easy to start smoking. Need for more literacy and education. Physical and psychological dependence, poverty, and stress. – Health Provider

Disease Management

> Hard to get people to quit. – Community Leader

Easy Access

> Because it is easy to purchase and legal for anyone over the age of 18. – Social Services Provider

Environmental Tobacco Smoke

> There is a huge number of people who smoke in this community, exposing their children and others to secondhand smoke. – Community Leader

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

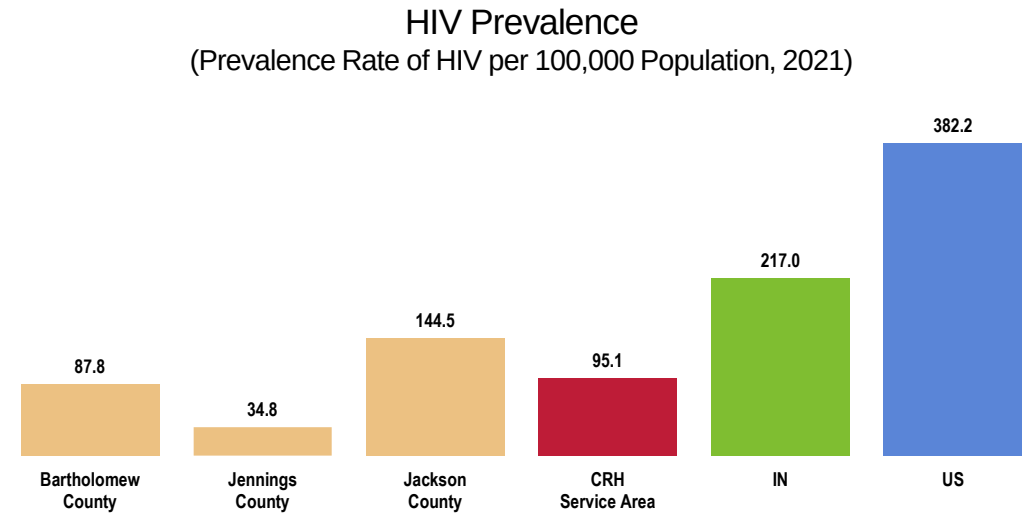
– Healthy People 2030 (https://health.gov/healthypeople)

HIV

In 2021, there was a prevalence of 95.1 HIV cases per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Considerably lower than the Indiana and US rates.

DISPARITY ► Highest locally in Jackson County.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

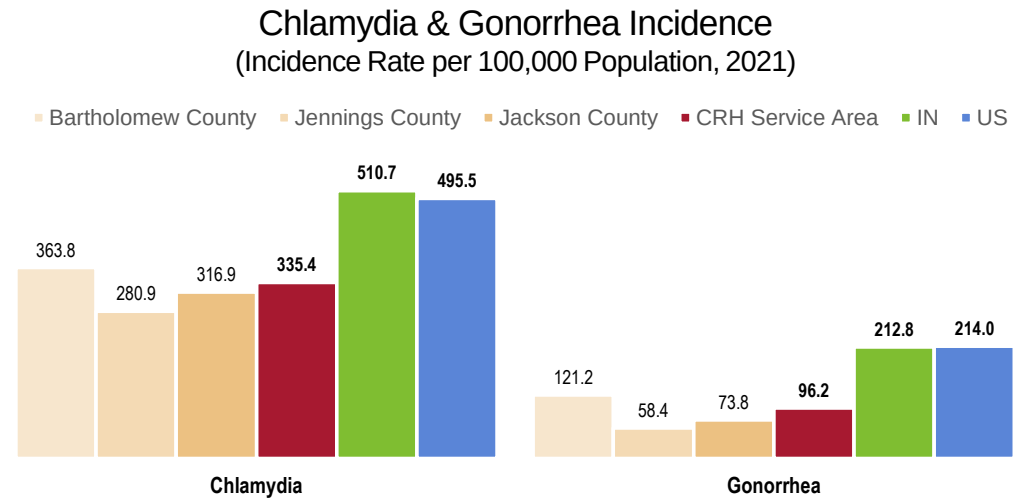
In 2021, the chlamydia incidence rate in the Columbus Regional Health Service Area was 335.4 cases per 100,000 population.

BENCHMARK ► Considerably lower than the Indiana and US rates.

The Columbus Regional Health Service Area gonorrhea incidence rate in 2021 was 96.2 cases per 100,000 population.

BENCHMARK ► Considerably lower than the Indiana and US rates.

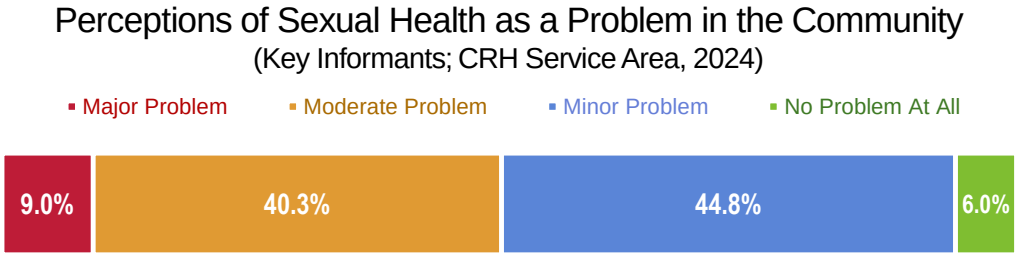
DISPARITY ► Highest in Bartholomew County.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

Key informants taking part in an online survey generally characterized *Sexual Health* as a "minor problem" in the community.



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

> We do not have a specialized clinic that treats HIV. – Physician
>
> We have an increase in STIs in the county. Lack of resources for individuals. Lack of education. – Public Health Representative
>
> No Planned Parenthood facility. – Physician

Awareness/Education

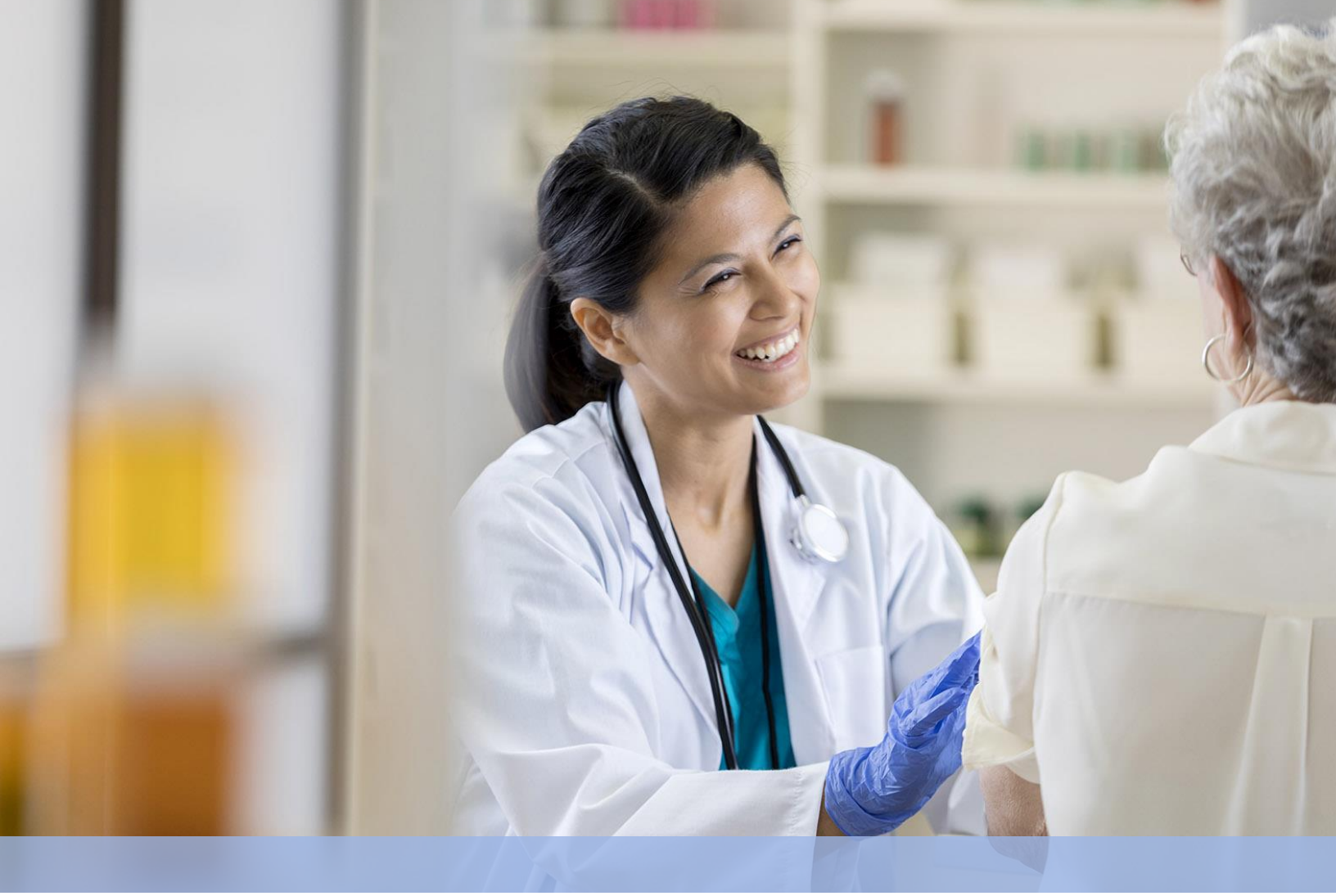
> Having a healthy sexual understanding of STDs, HIV, and other diseases isn’t a problem; not having it is a problem. – Community Leader
>
> I think it is a hot topic and not covered often or well in schools. This tends to be a very conservative community, and parents do not want their children educated outside the home but are not providing proper education in the home. Teen pregnancy seems to still be an issue in this community, and I think it is mostly due to lack of education and realism that teens will not necessarily practice abstinence. – Community Leader

Vulnerable Populations

> High rate of STDs among the unhoused community. Not enough education or protection available. – Social Services Provider

Incidence/Prevalence

> STDs and hepatitis are on the rise in Bartholomew County. – Public Health Representative



ACCESS TO HEALTH CARE

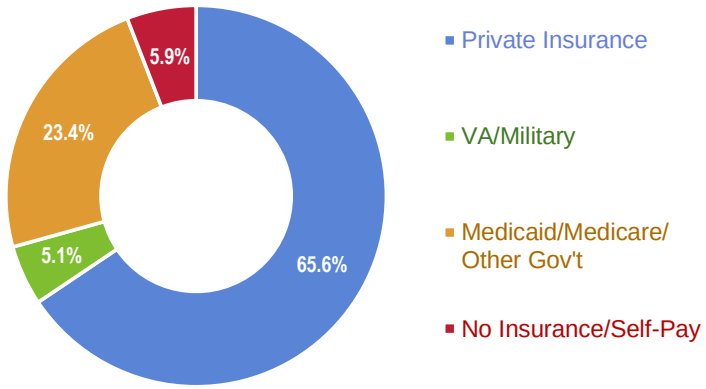
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 65.6% of Columbus Regional Health Service Area adults age 18 to 64 report having health care coverage through private insurance. Another 28.5% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage
(Adults 18-64; CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 5.9% report having no insurance coverage for health care expenses.

BENCHMARK ► Lower than the statewide percentage. Satisfies the Healthy People 2030 objective.

TREND ► Denotes a significant decrease from the 1996 baseline.

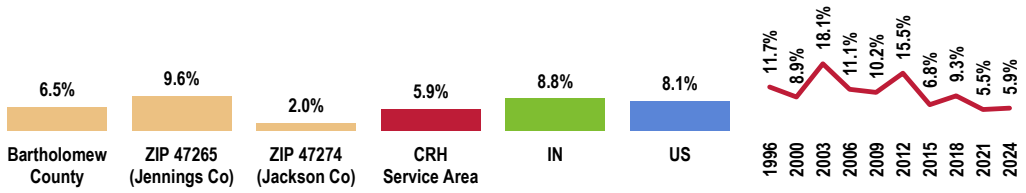
DISPARITY ► Lowest in Jackson County ZIP Code 47274. Those with lower incomes and especially Hispanic respondents are more likely to report being without health insurance.

Lack of Health Care Insurance Coverage

(Adults 18-64)

Healthy People 2030 = 7.6% or Lower

CRH Service Area



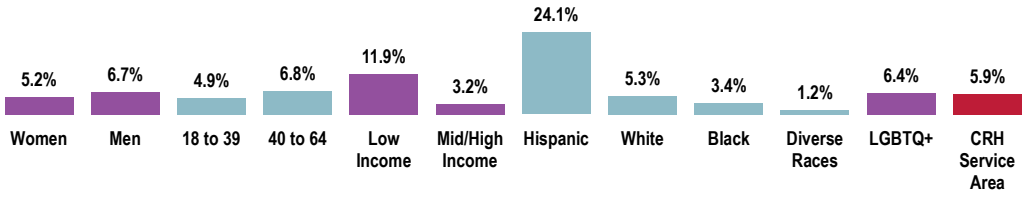
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Lack of Health Care Insurance Coverage

(Adults 18-64; CRH Service Area, 2024)

Healthy People 2030 = 7.6% or Lower



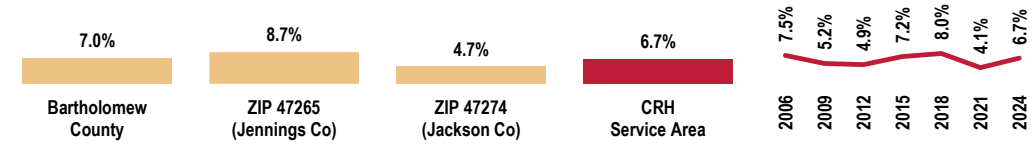
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Insurance Instability

Among insured respondents, 6.7% experienced a time without health care coverage at some point in the past year.

Went Without Health Care Insurance Coverage in the Past Year
(Among Insured Adults ; CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 317]
Notes: • Asked of all insured respondents.
• Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Difficulties Accessing Services

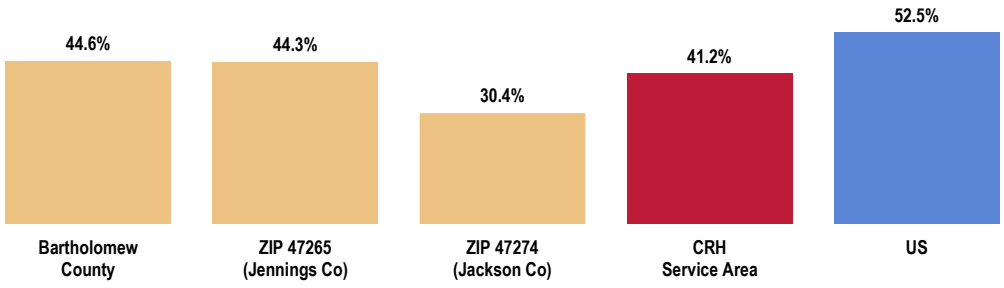
This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

A total of 41.2% of Columbus Regional Health Service Area adults report some type of difficulty or delay in obtaining health care services in the past year.

BENCHMARK ► Lower than found nationally.

DISPARITY ► Comparatively lower in Jackson County ZIP Code 47274. More often reported among women, adults age 18 to 39, Black or African American residents, and LGBTQ+ respondents.

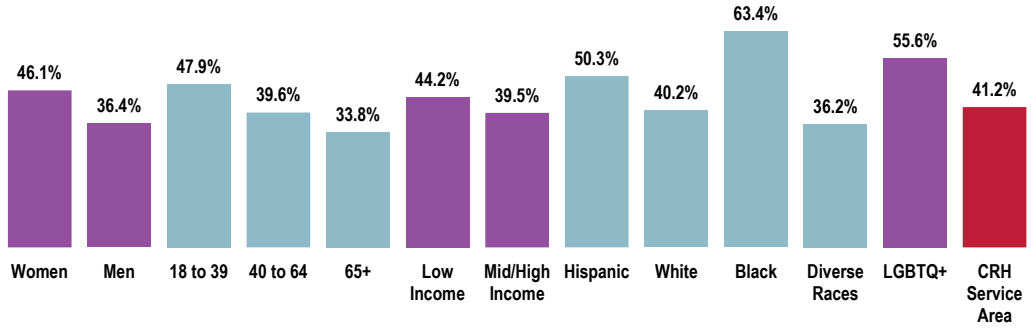
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(CRH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.
• Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Barriers to Health Care Access

Of the tested barriers, appointment availability impacted the greatest share of Columbus Regional Health Service Area adults.

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

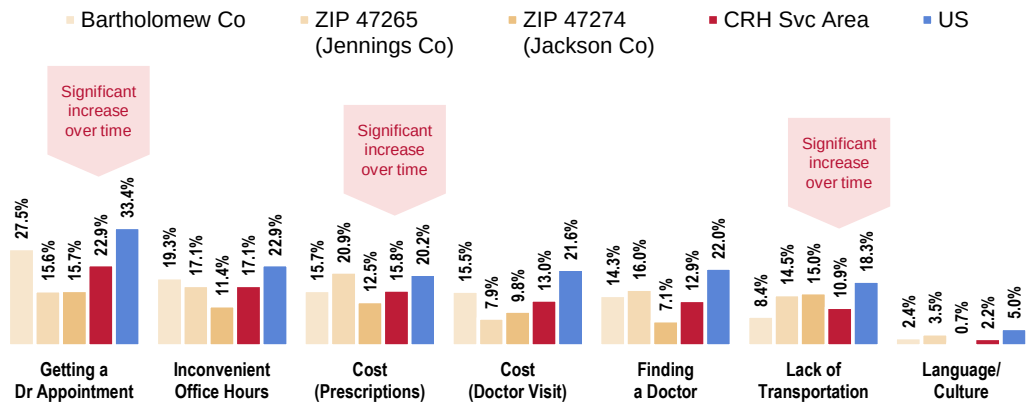
Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

BENCHMARK ► Each tested barrier affects service area adults significantly less than it does adults across the US.

TREND ► Difficulty with **appointment availability**, **cost of prescriptions** and lack of **transportation** as barriers has increased over time.

DISPARITY ► **Cost of a physician visit** and **appointment availability** were mentioned more often as barriers in Bartholomew County, while **inconvenient office hours** and difficulty **finding a physician** were mentioned less often in Jackson County ZIP Code 47274.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 6-12]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

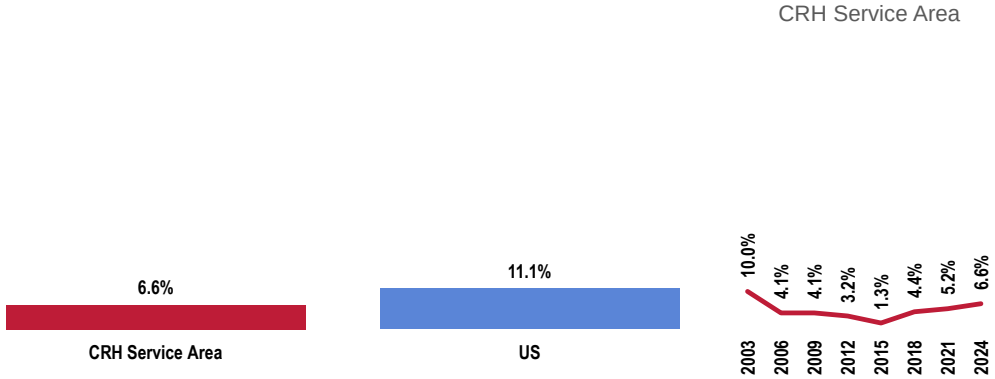
Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

A total of 6.6% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

BENCHMARK ► Lower than found nationally.

Had Trouble Obtaining Medical Care for Child in the Past Year
(CRH Service Area Children Age 0-17)



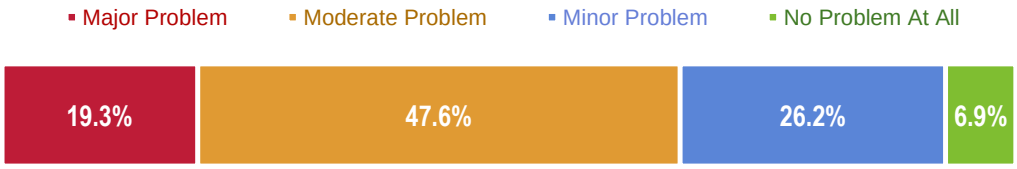
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with a child age 0-17 at home.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants; CRH Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care for Uninsured/Underinsured

> Access for uninsured and underinsured residents. – Community Leader
>
> Lack of affordable insurance. Long waits for appointments with a doctor. – Community Leader
>
> Lack of insurance and lack of knowledge about available services for patients who do not have insurance. – Physician

The families don't qualify for medical insurance or Medicare benefits. More families don't have treatment or prevention care or regular care. – Health Provider

Providers that see Medicaid adults and children. Appointment availability, accepting new patients, lack of specialists in the area, especially for pediatric specialists. – Health Provider

Those with no insurance or underinsured, especially children. – Public Health Representative

Lack of providers for uninsured adults and pediatrics. Need a dental clinic for those without dental insurance and for kids without insurance. – Public Health Representative

Lack of insurance and access to health care due to financial constraints. Transportation issues for some. – Community Leader

Transportation

There are barriers to accessing health care services, one of which is transportation. There are little to no methods of transportation for individuals experiencing a mental health crisis. Additionally, a lack of after-hours health care services is another challenge related to accessing health care services. – Community Leader

I work with a vulnerable population that doesn't always have access to transportation or know where to go to get their medication. I also worry about individuals that need to get medication on a regular basis, if they will remember to pick it up or even be able to pick it up due to mobility issues, transportation issues, etc. – Community Leader

Transportation to and from care providers. Access to care at a time that works for families – for example, after 5 p.m. Maternal and newborn appointments are not located near each other. – Health Provider

Transportation barriers, especially for those county residents outside of the city bus limits, prevent access. Additionally, many community members do not have access to insurance and funding to allow for health care services. – Community Leader

LACK OF TRANSPORTATION, especially for low-income people and people over 65. Access to affordable health insurance is also a huge problem for people working at nonprofits, and that is 10% of the population. People on Medicaid or Medicare do not have access to a wheelchair-accessible vehicle. Verida, the provider through Medicaid Waiver, just doesn't show up half the time. – Community Leader

Access to Care/Services

There are no health clinics in East Columbus. People from the State Street area have to travel to receive any sort of care, and some patients have barriers to reliable transportation. The bus is there; however, some patients cannot afford a bus pass. Unfortunately, we are only planning to make the problem worse by continuing to move health care offices further and further away to the west side. – Community Leader

Lack of capacity within the community, as well as financial limitations to pay for services or copays. – Community Leader

I am still relatively new in this community but have jumped right in trying to get involved in helping where I can. What I have already noticed is the time it takes for people to get some type of urgent mental health intervention unless they are eligible for hospitalization or residential treatment. The less serious cases, but still in pretty urgent need, have to wait for counseling services. This, I believe, is the biggest challenge I have seen so far. – Social Services Provider

Our kids could really benefit from having access to a health clinic through the schools. – Community Leader

With respect to the health of our community, the lack of access to a psychiatrist is by far the largest hole we have, and the consequences of that absence are becoming more apparent daily. We need more psychiatrists and actual access to them. – Physician

Lack of Providers

Shortage of physicians. Hard to be seen by specialists who are physicians and have the specialty training, instead of nurse practitioners or physician assistants working in a specialty office but with no specialized training. – Physician

We may be facing a shortage of primary care and medical doctor providers in the near future. – Physician

The overall number of providers. – Community Leader

Not enough specialty doctors in the area. – Community Leader

Lack of primary care providers. – Community Leader

Affordable Care/Services

Expense. – Social Services Provider

The biggest challenges are cost, lack of availability (such as appointments and medical providers), lack of knowledge of how to navigate the system, and resources. – Community Leader

Cost. – Social Services Provider

Income/Poverty

> Income and transportation. – Community Leader
>
> Wide division of wealth makes accessing health care for many individuals and families in our community difficult. – Community Leader

Government/Policy

> As the only Western nation without a universal health care mandate, the US has made choices which unfortunately trickle down to the local level. These federal-level decisions impact folks on the bottom rungs of the ladder whose employers do not provide health insurance and therefore do not have easy access to affordable care. This, in turn, leads much of that segment of the population to defer making proactive health care decisions, leading to worse health outcomes. – Community Leader

Language Barrier

> Large demographic who are unable to speak English. Finances! Mental health concerns. Lack of knowledge regarding the availability of WellConnect & VIMCare. Lack of health insurance. Lack of employment. Homelessness: an individual is unlikely to seek health care if they do not even have a home. – Public Health Representative

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

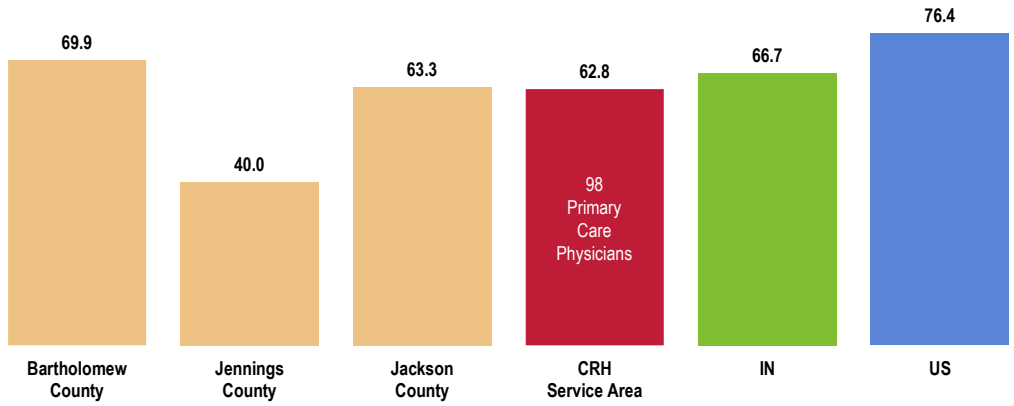
Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

In 2021, there were 98 primary care physicians in the Columbus Regional Health Service Area, translating to a rate of 62.8 primary care physicians per 100,000 population.

BENCHMARK ► Lower than the US ratio.

DISPARITY ► Lowest in Jennings County.

Number of Primary Care Physicians per 100,000 Population
(2021)



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

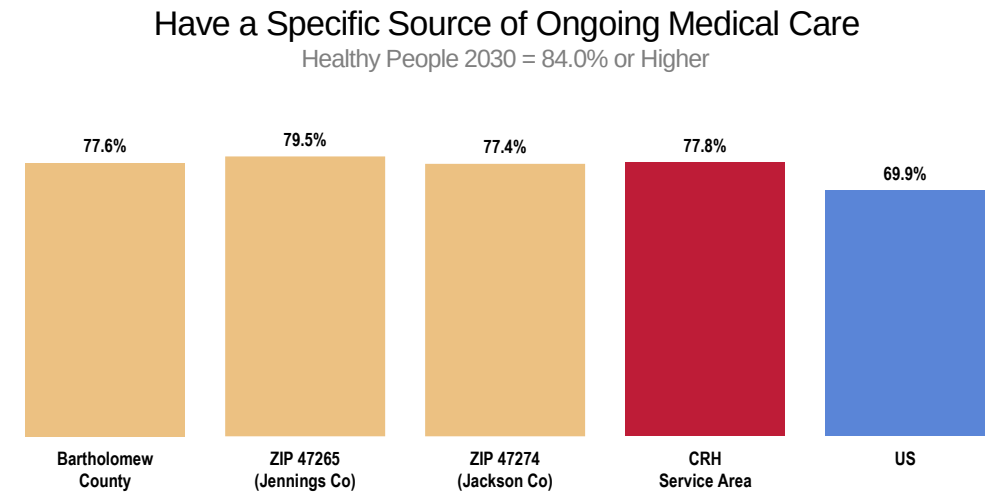
Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, public health clinic, community health center, urgent care or walk-in clinic, military/VA facility, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 77.8% of Columbus Regional Health Service Area adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► More favorable than the US finding but fails to satisfy the Healthy People 2030 objective.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 118]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

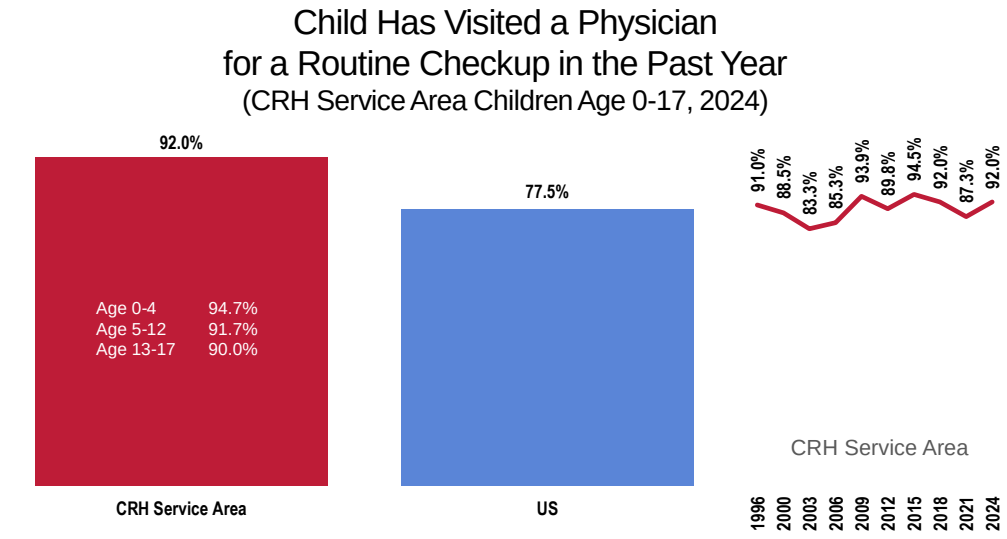
Notes:
- Asked of all respondents.

Utilization of Primary Care Services

Children

Among surveyed parents, 92.0% report that their child had a routine checkup in the past year.

BENCHMARK ► Much more favorable than the national percentage.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

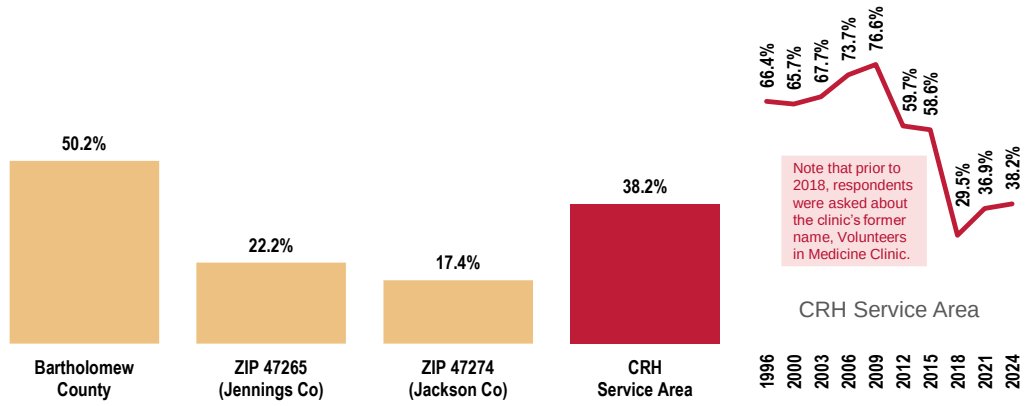
Awareness of VIMCare Clinic

More than one-third of survey respondents (38.2%) are aware of the VIMCare Clinic at Columbus Regional Hospital.

TREND ► Awareness has decreased considerably over time. (Note that prior to 2018, respondents were asked about the clinic as the Volunteers in Medicine clinic in Columbus).

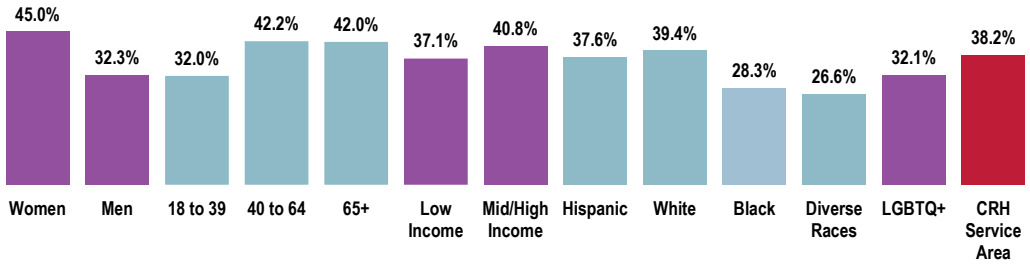
DISPARITY ► Awareness of VIMCare is lower in Jennings County ZIP Code 47265 and Jackson County ZIP Code 47274. Others less likely to express awareness include men, adults age 18 to 39, and residents who are Black/African American or of diverse races.

Aware of the VIMCare Clinic at Columbus Regional Hospital



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 328]
Notes: ● Asked of all respondents.
● Prior to 2018, respondents were asked about the clinic as the Volunteers in Medicine clinic in Columbus.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Aware of the VIMCare Clinic at Columbus Regional Hospital
(CRH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 328]
Notes: ● Asked of all respondents.
● Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

Adults

A total of 64.3% of Columbus Regional Health Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

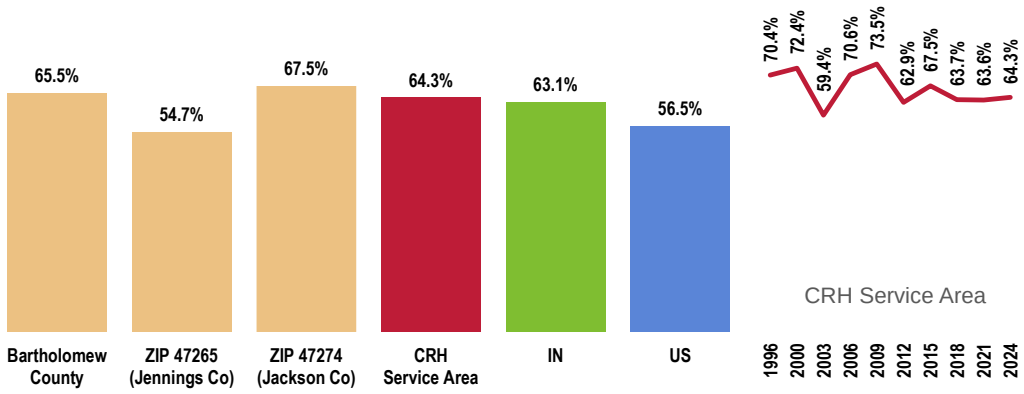
BENCHMARK ► More favorable than the national percentage. Satisfies the Healthy People 2030 objective.

TREND ► Denotes a significant decrease from the 1996 baseline.

DISPARITY ► Lowest in Jennings County ZIP Code 47265. Those less likely to report a recent dental visit include male respondents, adults age 18 to 39, lower-income respondents, Hispanic residents, residents of diverse races, and LGBTQ+ respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



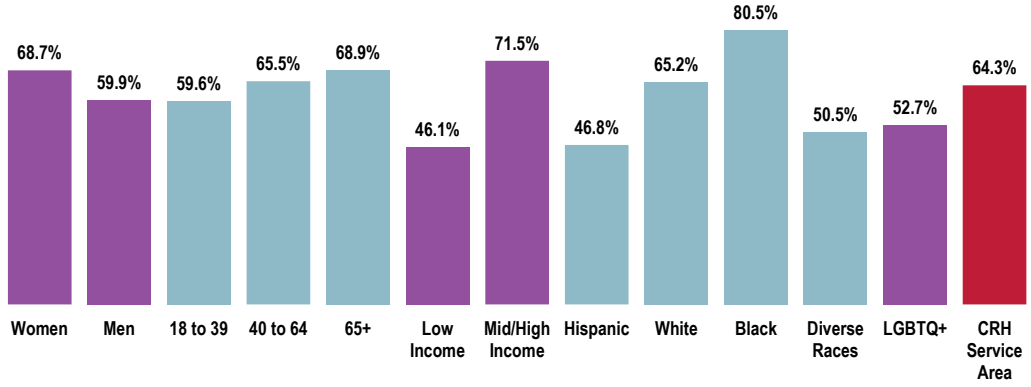
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Have Visited a Dentist or Dental Clinic Within the Past Year

(CRH Service Area, 2024)

Healthy People 2030 = 45.0% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Note that the samples of Black/African American and Diverse Races respondents are each <50; use caution when interpreting these results.

Children

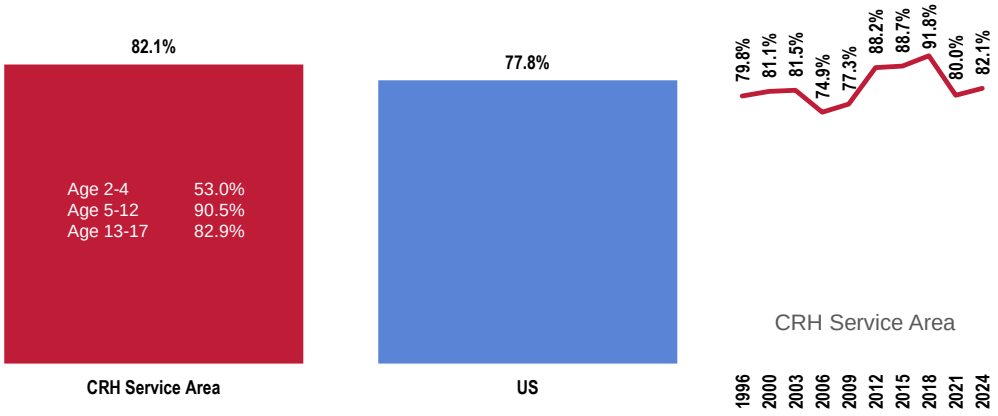
A total of 82.1% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(CRH Service Area Children Age 2-17, 2024)

Healthy People 2030 = 45.0% or Higher

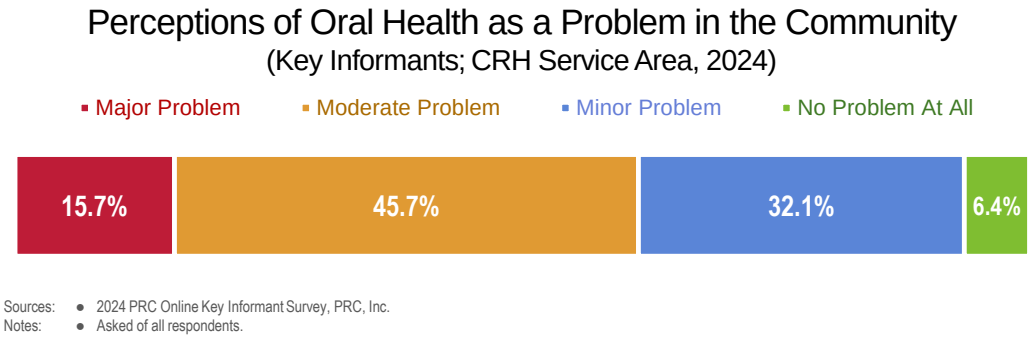


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 93]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents with children age 2 through 17.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> Cost of dental care. – Social Services Provider
>
> Dental care is expensive, and there is not much affordable dental care in our area for patients who do not have insurance. – Physician
>
> Dental health is an issue for low-income families. It seems to be viewed as nice to have, but not necessary. – Community Leader
>
> Dental work is very expensive. Very few dentists accept Medicaid. Even if a person has Medicaid/HIP, there are procedures that are not covered. Sometimes patients are referred to clinics in Indianapolis, only to find copays that are not affordable. – Community Leader
>
> Affordability and insurance are not as good for oral health as medical health. – Social Services Provider

Access to Care for Medicare/Medicaid Patients

> Los of cavities in young patients and lack of dentists who will see those under the age of 3, especially those with Medicaid. – Physician
>
> There is a lack of dentists accepting Medicaid and HIP, especially pediatric dentistry. – Social Services Provider
>
> There are not enough providers for people on Medicaid. – Community Leader

Access to Care for Uninsured/Underinsured

> We need a dental clinic for those without insurance for adults and children. – Public Health Representative
>
> The dental hygienist at Bartholomew County Health Department screens children on a weekly basis at area schools, and she reports high levels of tooth decay. Most people that BCHD evaluates do not have insurance or the ability to pay out-of-pocket. – Public Health Representative

Incidence/Prevalence

> Public data. – Community Leader
>
> Many people have no or only some of their teeth, due to poor health. – Community Leader

Alcohol/Drug Use

> Use of drugs and tobacco have caused some residents to have serious dental issues. – Community Leader
>
> High rate of drug use, high price of services. – Social Services Provider

Impact on Quality of Life

> Oral health is an important aspect of overall health that is often neglected. This neglect leads to larger health issues. – Health Provider

Vulnerable Populations

> We have and increasing number of immigrants coming to the country that do not qualify for Medicaid. There are many who cannot afford dental work and do not qualify for Medicaid. Many of these are elderly. I am the dental coordinator at the health department, and I send people out of the county to the Seymour FQHC, but many do not have transportation and may not be able to afford that clinic, either. Although there is the Dental Lifeline (Donated Dental Services), many do not qualify for that, and the waiting list may be long or if too busy applications are not accepted. It causes me distress that so many children and adults in our county have severe dental needs that are not being met. This would be true even if we did not have any immigrants. There is no clinic or mobile dental service to help. When I lived in Terre Haute, Indiana, a 27-year-old woman died from a dental infection, which inspired the St. Ann Dental Clinic for those who fall through the cracks. – Public Health Representative

Awareness/Education

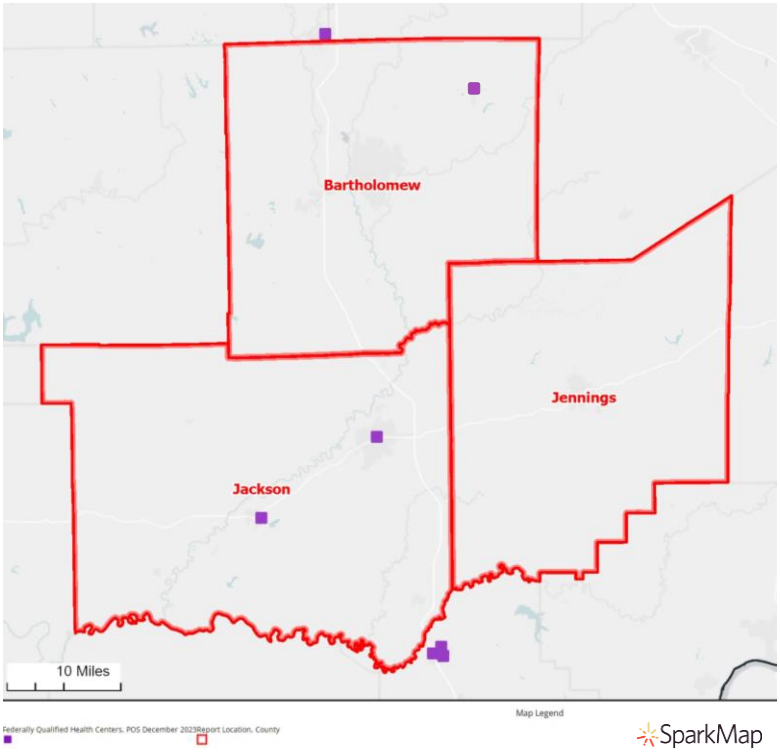
> In some cases, individuals aren't taught the importance of oral health care because parents are concerned about paying bills. Also, dental care insurance is expensive. Some individuals aren’t taught smoking, unhealthy eating, and proper brushing teeth are essential to healthy gums and teeth. – Community Leader

LOCAL RESOURCES

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the Columbus Regional Health Service Area as of December 2023.



Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Alivio Clinic
- Alliance for Substance Abuse Programs
- Bartholomew Consolidated School Corporation
- Bartholomew County Health Department
- Centerstone
- City Bus
- ColumBUS
- Columbus Regional Health
- Columbus Regional Health Physicians
- Columbus Regional Hospital
- Family Services
- Health Department
- Healthy Communities
- Hospitals
- Immunization Clinics
- Jackson County Health Clinic
- Just Friends
- Love Chapel
- Medicab
- Mental Health Services
- Milk Bank
- NexusPark
- Nurse-Family Partnership
- Peyton Manning Children's Hospital
- PromptMed
- Riley Hospital
- Salvation Army
- Stride Center
- Su Casa
- The Center for Counseling
- Thrive Alliance
- Transportation
- Treatment and Support Center
- United Way
- VIMCare
- WellConnect
- WindRose Health Network
- WindRose Health Network Hope

Cancer

- American Cancer Society
- Ascension St. Vincent Hospital
- Columbus Regional Health
- Columbus Regional Health Cancer Center
- Columbus Regional Hospital
- Doctor's Offices
- Hospice
- IU Health
- IU Simon Cancer Center
- Lung Cancer Center
- Our Hospice of South Central Indiana
- Schneck Medical Center
- Schneck Cancer Center
- St. Bartholomew Cancer Support Group
- St. Francis Cancer Center
- Thrive Alliance

Diabetes

- American Diabetes Association
- American Heart Association
- Bartholomew County Food Insecurity Coalition
- Bartholomew Regional Hospital
- Centerstone
- Columbus Health Department
- Columbus Regional Health
- Columbus Regional Health Diabetes Education
- Columbus Regional Health Endocrinology
- Columbus Regional Health Nutrition Program
- Columbus Regional Health Primary Care
- Dining With Diabetes
- Doctor's Offices
- Fitness Centers/Gyms
- Food Banks/Food Pantries
- Franciscan Health
- Health Department
- Healthy Communities
- Hospitals
- Jackson County Health Clinic
- Johnson Memorial Health Diabetes Care Center

- LiveWell Center
- Love Chapel
- Medication Assistance Program
- Mill Race Center
- NexusPark
- Nutrition Services
- Parks and Recreation
- Purdue Extension Office
- Schneck Medical Center Endocrinology
- School System
- SNAP Program
- VIMCare
- Weight Loss Institute
- WindRose Health Network

Disabling Conditions

- Access Ability
- Assisted Living
- Cognitive and Behavioral Therapy
- ColumBUS
- Columbus Regional Health
- Counseling
- Developmental Services
- Doctor's Offices
- ECF Respite
- Home Care
- Hospice
- Insurance
- Just Friends
- Mill Race Center
- My Mobility
- Pain Clinic
- Physical Therapy/Occupational Therapy
- Quinco
- Rehab Facility
- Skilled Nursing
- Social Security
- Social Services
- The Arc
- Thrive Alliance
- United Way
- VIMCare
- Vocational Rehab

Heart Disease & Stroke

- Ascension St. Vincent Hospital
- Cardiac Rehab
- Columbus Regional Health
- Columbus Regional Health Cardiology
- Columbus Regional Hospital
- Doctor's Offices
- Educational Programs
- Fitness Centers/Gyms
- Health Department
- Healthy Communities
- Healthy Communities Tobacco Cessation
- Hospitals
- Indiana Department of Health
- Mill Race Center
- NexusPark
- Nutrition Services
- Purdue Extension Office
- Quit Now Indiana
- Schneck Medical Center
- VIMCare
- Wakeman VA Clinic
- WellConnect
- WindRose Health Network

Infant Health & Family Planning

- Bartholomew Consolidated School Corporation
- Birthing Center
- Child Fatality Review
- Clarity Pregnancy Care Center
- Columbus Regional Health
- Columbus Regional Health Breastfeeding Support
- Community Partners
- Doctor's Offices
- Fetal Infant Mortality Review
- First Steps
- Franciscan Health
- Health Department
- Healthy Communities
- Healthy Families
- Human Services
- Indiana Division of Family Resources
- Infant Mortality Task Force
- Nurse n' Chat
- Nurse-Family Partnership
- Planned Parenthood
- Sage Direct Care
- VIMCare
- WellConnect
- WIC

Injury & Violence

- Bartholomew County Sheriff's Department
- Be SMART Gun Safety Program
- Columbus Police Department

- Family School Partners
- Indiana State Police
- Law Enforcement
- Moms Demand Action
- School System
- Turning Point
- VIMCare

Mental Health

- Adult & Child Health
- Adult Inpatient Facility
- Alliance for Substance Abuse Progress
- Ascend Counseling
- Axon
- Bartholomew Consolidated School Corporation
- Bartholomew County Jail
- Behavioral Health
- Center for Apostolic Counseling
- Centerstone
- Churches
- Columbus Behavioral Center
- Columbus Counseling Partners
- Columbus Regional Health
- Columbus Regional Health Behavioral Health Services
- Columbus Regional Health Mental Health Unit
- Columbus Regional Hospital
- Community Downtown
- Community Partners
- Cornerstone Mental Health
- Council for Youth Development
- Counseling
- Counseling Counts
- Dawn Doup Counseling
- Doctor's Offices
- Educational Programs
- Ellie Mental Health
- Family Services
- Firefly Children & Family Alliance
- Foundation for Youth
- Healthy Communities
- Hospitals
- Imprint
- Indiana University
- Inpatient Mental Health
- IU Columbus Mental Health Counseling Center
- Jail
- LifeWorks
- LiveWell Center
- Mental Health Counseling Centers
- Mental Health First Aid
- Mental Health Matters
- Mental Health Services
- Mental Health Treatment Court
- Mill Race Center
- MyCare Family Medicine
- National Alliance on Mental Illness
- National Youth Advocate Program
- Nurse n' Chat
- Parks and Recreation
- Postpartum Support Group
- Private Mental Health Providers
- Psychology Today
- Public Library
- Rau Family Medicine
- Recovery Cafe
- Recovery Engagement Center
- Recovery Programs
- School System
- Social Services
- SPARK
- St. Peter’s Lutheran Church
- Stride Center
- Support Groups
- The Arc
- The Center for Counseling
- Thrive Alliance
- Treatment and Support Center
- Turning Point
- United Way
- Veterans Services
- VIMCare
- WindRose Health Network
- Youth Services Center

Nutrition, Physical Activity, & Weight

- American Heart Association
- Bariatric Center
- Bariatric Surgery
- Bartholomew Consolidated School Corporation
- Bartholomew County
- Bartholomew County Food Insecurity Coalition
- Bike Clubs
- City of Columbus
- Columbus Parks and Recreation
- Columbus Regional Health
- Columbus Regional Health Bariatric Program
- Columbus Regional Health Nutrition Program
- Columbus Regional Health Weight Loss
- Community Gardens
- CrossFit

- Doctor's Offices
- Farmer's Markets
- Fitness Centers/Gyms
- Food Stamps
- Foundation for Youth
- Girls on the Run
- Health Department
- Healthy Communities
- Hot Meal Sites
- LiveWell Center
- Love Chapel
- Mill Race Center
- NexusPark
- Nutrition Services
- Parks and Recreation
- Planet Fitness
- Purdue Extension Office
- School System
- Silver Sneakers Program
- SNAP Program
- Teaching Kitchen
- Tipton Lakes Athletic Club
- Total Fitness
- VIMCare
- Weight Loss Institute
- Weight Loss Programs
- Weight Watchers
- WellConnect
- Wellness Classes
- WIC
- YMCA
- Youth Sports Clubs/Activities

Oral Health

- Affordable Dental Care
- Alliance for Substance Abuse Progress
- Bartholomew County Health Department
- Columbus Regional Health
- Community Health Center of Jackson County
- Dental Care of Columbus
- Dentist's Office
- Donated Dental Services
- Health Department
- Indiana University
- Jackson County Health Clinic
- Riley Hospital
- School System
- VIMCare

Respiratory Diseases

- American Lung Association
- Columbus Regional Health
- Columbus Regional Health Better Breathers Club
- Columbus Regional Health Lung Center
- Doctor's Offices
- Health Department
- Healthy Communities Tobacco Cessation
- PromptMed
- VIMCare

Sexual Health

- Bartholomew Consolidated School Corporation
- Clarity Pregnancy Care Center
- Columbus Regional Health
- Doctor's Offices
- Health Department
- School System

Social Determinants of Health

- Access Ability
- Affordable Housing Programs
- Alliance for Substance Abuse Progress
- Bartholomew Consolidated School Corporation
- Bartholomew County Government
- Bartholomew County Health Department
- Bartholomew County Works Program
- Brighter Days
- Centerstone
- Child Care Tax Credits
- Churches
- City of Columbus
- Civic Lab
- Columbus Area Chamber of Commerce
- Columbus Housing Authority
- Columbus Regional Health
- Community Engagement Center
- Community Partners
- County Trustees
- Cummins LiveWell
- Employers
- EquityWORKS
- Family Resources
- Family Self-Sufficiency Program
- Family Services
- Farmer's Markets
- Federal Housing Agency

- Food Banks/Food Pantries
- Foundation for Youth
- Government Housing
- Healthy Communities
- Homeless Shelters
- Horizon House
- Housing Authority
- HUD
- Human Resources
- Human Rights Commission
- Human Rights Department
- Human Services, Inc. (HSI)
- Indiana Health and Human Services
- Indiana Health Department
- Indiana University
- Lincoln Central Neighborhood Family Center
- Love Chapel
- McDowell Adult Education Center
- McKinney-Vento Law
- Mental Health Matters
- National Association for the Advancement of Colored People (NAACP)
- OB Nurse Navigator
- Public Transportation
- Recovery Houses
- School System
- Section 8 Columbus Housing
- Shelter
- SNAP Program
- Social Services
- State of Indiana
- Stride Center
- Su Casa
- Supportive Housing
- Thrive Alliance
- Tobacco Cessation
- Transitional Housing
- Treatment and Support Center
- Trustees
- Turning Point
- United Way
- VIMCare
- WellConnect
- WIC
- WindRose Health Network
- Workforce Development

Substance Use

- AA/NA
- Alliance for Substance Abuse Progress
- Bartholomew County
- Bartholomew Consolidated School Corporation
- Bartholomew Substance Abuse Council
- Celebrate Recovery
- Centerstone
- Certified Drug and Alcohol Counselors
- Churches
- City of Columbus
- Columbus Behavioral Center
- Columbus Regional Health
- Columbus Regional Health Addiction Treatment Center
- Columbus Regional Health Behavioral Health Services
- Community Downtown
- Community Education
- Doctor's Offices
- Drug Recovery Court
- Drug Rehabilitation Programs
- Educational Programs
- Family Services
- Fresh Start Recovery Center (VOA)
- Groups
- Groups Recover Together
- Halfway Houses
- Healthy Communities
- Intensive Outpatient Programs
- IYG Counseling
- LifeWorks
- Mosaic
- New Beginnings
- Private Counselors
- Recover Out Loud
- Recovery Cafe
- Recovery Houses
- Sober Homes
- Stride Center
- Tara Treatment Center
- The Sanctuary
- Thrive Alliance
- Treatment and Support Center
- United Way
- Urgent Care Centers
- Valley Vista

Tobacco Use

- Alliance for Substance Abuse Progress
- Baby & Me - Tobacco Free
- Bartholomew Consolidated School Corporation
- Bartholomew County
- CATCH My Breath
- Centerstone

City of Columbus

Columbus Regional Health

Columbus Regional Health Smoking Cessation Classes

Columbus Regional Hospital

D.A.R.E.

Doctor's Offices

Foundation for Youth

Health Department

Healthy Communities

Healthy Communities Tobacco Cessation

Lawmakers

LiveWell Center

Quit Now Indiana

Stride Center

Tobacco Awareness Action Team

Tobacco Cessation

Tobacco Prevention Programs

Treatment and Support Center

APPENDIX

EVALUATION OF IMPACT OF 2021-2023 ACTIVITIES

Community Benefit 2021-2023

Over the past three years, Columbus Regional Health has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $5.8 million in community benefit, excluding uncompensated Medicare.
- More than $32.4 million in charity care and other financial assistance programs.

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

Columbus Regional Health CRH) conducted its last CHNA in 2021 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that CRH would focus on developing and/or supporting strategies and initiatives to improve:

- Mental Health
- Substance Use Disorder
- Access to Primary Care
- Disease and Injury Prevention
- Infant Mortality Prevention

Strategies for addressing these needs were outlined in Columbus Regional Health's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken CRH to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Mental Health	
Community Health Need	Identify & address challenges and improve the mental health system for the well-being of youth and adults in Bartholomew County
Goal(s)	• Effectively lead the community's Mental Health Matters initiative • Design and develop a preliminary dashboard of Community Mental Health Metrics • Identify, engage with, and empower an Ambassador Network to reach underserved populations to advocate for mental health awareness/de-stigmatization

Strategy 1: Assess current state of mental health in our community	
Target Population(s)	Resource Team leaders, Mental Health Matters staff, community
Partnering Organization(s)	Internal: Healthy Communities External: City of Columbus, Bartholomew County, Columbus Regional Health, Centerstone of Indiana, Bartholomew County School Corp., United Way
Results/Impact	• Identified current state, gaps, and barriers to mental well-being as well as potential solutions • Developed map of 3-year initiatives

Strategy 2: Develop team of Health Equity Ambassadors	
Target Population(s)	Underrepresented micro-communities
Partnering Organization(s)	Internal: Healthy Communities Mental Health Team External: First Presbyterian Church, Su Casa, Columbus Area Arts Council, Office of Human Rights (City of Columbus), United Way, Love Chapel, Brighter Days, Thrive Alliance, Mill Race Center, San Souci, Columbus Chamber, Council for Youth Development, Foundation for Youth, Inclusive Options, Pride Alliance and others
Results/Impact	• An active and informed Ambassador Network of 30+ ambassadors was developed and is being piloted • Evidence-based trainings offered, resource sharing, and community engagement events are held with positive feedback and good attendance

Strategy 3: Credible Minds	
Target Population(s)	Community as a whole
Partnering Organization(s)	Internal: Healthy Communities External: Bartholomew County Sheriff, Heritage Fund, Barth County Health Dept, mental health service providers
Results/Impact	• Strategy is developed for identifying areas of greatest need for the MH system of support • Usage metrics are tracked and reported to leadership and the community

Priority Area: Substance Use Disorder	
Community Health Need	Sustainable System of Prevention and Support for Substance Use Disorder
Goal(s)	• Sustainable Sober Living model and homes • Shift focus from new treatment solutions to prevention and stigma elimination • Transition long-term sustainability from ASAP Initiative to the community

Strategy #1: Sustainable model for sober living homes in Columbus	
Target Population(s)	Adults in treatment and support for SUD
Partnering Organization(s)	Internal: Healthy Communities External: ASAP, Ascension, Recovery Services, Thrive Alliance, Volunteers of America, Centerstone, Bridge to Dove
Results/Impact	• Sustainable housing model developed, including 2 level-3 homes for men leaving incarceration, 1 level-3 home for women, and 2 level-2 homes for men. • Homes were successfully transitioned to Ascension Recovery Services and Volunteers of America (VOA) for long-term operation and sustainability

Strategy #2: Prevention and Stigma Elimination	
Target Population(s)	**Community at-large**
Partnering Organization(s)	Internal: Healthy Communities External: Alliance for Substance Abuse Progress (ASAP), Bartholomew Consolidated School Corp, Council for Youth Development, Foundation for Youth, Mill Race Center (Seniors), Soul's Truth Coaching
Results/Impact	• Over 600 adults have participated in stress management training • Six community members completed Overdose Lifeline evidence-based stigma reduction training • Media (including social) campaign initiated for reducing prescription misuse, importance of making healthy choices
Strategy #3: Transition Initiative to sustainable system of SUD prevention & support in the community	
Target Population(s)	All of Bartholomew County
Partnering Organization(s)	Internal: Healthy Communities External: Alliance for Substance Abuse Progress (ASAP), all Healthy Communities Partner organizations
Results/Impact	• CRH Foundation funded development of a Recovery Café in Columbus • CRH Foundation funding for implementation of "R-Fit", a fitness-based recovery support model • CRH Foundation prevention grant was used to develop stress management curriculum for teachers to use in schools with students • Opioid settlement funds distributed to community partner organizations • Funding for Sbustance Use Disorder initiatives received for prevention and expansion of Adult Drug Recovery Court and Family Recovery Court

Priority Area: Access to Primary Care	
Community Health Need	Access to primary healthcare, medication, and vital treatments for uninsured and under-insured residents
Goal(s)	• Increase number of adults and children with appropriate health insurance • Provide quality outpatient care to uninsured, and to newly arrived residents • Ensure all community residents receive necessary prescriptions, regardless of financial limitations

Strategy #1: VIMCare Clinic	
Target Population(s)	Underinsured and uninsured residents
Partnering Organization(s)	Internal: CRH Inpatient Units External: Windrose Clinic, United Way agencies
Results/Impact	VIMCare served: • In 2021 1,913 patients with 9,818 total visits • IN 2022 1,974 patients with 9,460 total visits and • In 2023: 2,410 individual patients with 9,721 total visits

Strategy #2: Medication Assistance Program (MAP)	
Target Population(s)	Underinsured and uninsured, low income residents
Partnering Organization(s)	Internal: Physician offices, CRH Foundation, External: Kroger, Sam's Club,
Results/Impact	• The total value of medications procured through all programs during this period: **$19,523,173.86** • The total of individual clients served during this time through all programs during this period: **807** • Total successful MAP applications completed and processed during this period: **3,302**

Strategy #3: Assist with insurance applications and complex paperwork, and facilitate connections to community organizations	
Target Population(s)	Underinsured and uninsured Adults and Children
Partnering Organization(s)	Internal: VIMCare clinic, Claim Aid External: Covering Kids and Families, United Way, Su Casa, Advocates for Children, Alliance for Substance Abuse Progress, Family Service, Firefly (Children's Bureau), Bartholomew County Health Dept, Treatment and Support Center (TASC)
Results/Impact	• As a result of cohort led by Healthy Communities and VIMCare clinic, 18 members of community organizations listed above obtained certification as Medicaid Navigators • CRH Foundation initiated agreements and provided funding to support hiring of 2 Insurance Navigators working with United Way and Covering Kids and Families

Priority Area: Disease and Injury Prevention	
Community Health Need	Evidence-based interventions to reduce incidence of preventable disease and injury
Goal(s)	• Support prevention and cessation of smoking/vaping among youth and adults • Provide opportunities for Supplemental Nutrition Assistance Program (SNAP) recipients to access higher quality food items at affordable prices • Increase physical activity for elementary students

Strategy # 1: Provide education and engage youth in prevention of tobacco use and vaping	
Target Population(s)	Youth
Partnering Organization(s)	Internal: Healthy Communities Tobacco Awareness Team External: Indiana Tobacco Prevention and Cessation, Bartholomew County School Corp., Flat Rock Haw Creek School Corp, Foundation for Youth, Council for Youth Development
Results/Impact	• Development of VOICE youth ambassador program in collaboration with Foundation for Youth, with 700 youth participating • Provided tobacco education to all area health classes- 3,900 students • Provided 25 classes to parents to educate on vaping • Ensured participation of local schools in annual youth tobacco surveys

Strategy # 2: Support tobacco cessation efforts to ensure success	
Target Population(s)	Adults who smoke or vape
Partnering Organization(s)	Internal: Healthy Communities Tobacco Awareness Team, CRH inpatient and outpatient facilities External: Indiana Tobacco Prevention and Cessation, Bartholomew County Public Health Dept.
Results/Impact	• Provided 200 nicotine replacement products to 161 individuals wishing to quit • Developed referral pathway within electronic medical record to support quit attempts • Provided 3 cessation class series to 14 individuals at no charge • Provided 3 evidence-based smoking prevention education trainings for parents to Headstart staff.

Strategy # 3: Provide Double Bucks program at the Farmer's Market	
Target Population(s)	Supplemental Nutrition Assistance Program (SNAP) enrolled residents
Partnering Organization(s)	Internal: Healthy Communities staff, Healthy Lifestyles Team and student interns External: City of Columbus, Farmer's Market vendors, Food Insecurity Coalition
Results/Impact	• Enables SNAP beneficiaries to obtain $2 worth of food at market for every $1 spent in SNAP benefits • $5,292 EBT charges run, resulting in $10,584 spent at Farmer's Market in 2022, 2023 (COVID prevented attendance at 2021 market)

Strategy #4: Implementation of physical activity-centered programs within the school system	
Target Population(s)	Bartholomew County School Corp. elementary students
Partnering Organization(s)	Internal: Healthy Communities Healthy Lifestyle team External: Bartholomew County School Corp., City of Columbus

Results/Impact	• 449 elementary students participated in cross country program in 2023, including 12% Hispanic ethnicity and 7% black and black biracial students.
	• Supported organization and implementation of the Kids Fun Run in conjunction with Mill Race Marathon:
	  ○ 590 students participated in 2021
	  ○ 1,145 in 2022 and
	  ○ 1,424 in 2023
	• Funded elementary fitness run:
	  ○ 340 participated in 2021
	  ○ 160 in 2022 and
	  ○ 330 in 2023

Strategy #5: Food Insecurity Coalition	
Target Population(s)	Residents needing food assistance and nutritional resources
Partnering Organization(s)	Internal: Healthy Communities Healthy Lifestyles Team External: Downtown Farmer's Market (City of Columbus), Purdue Extension
Results/Impact	• Distribute thousands of food assistance brochures in English and Spanish • Menu planning, food safety, and nutrition education • Collaborated on assessment of food security in community of Bartholomew County

Priority Area: Infant Mortality Prevention	
Community Health Need	Reduce Infant Mortality Rate
Goal(s)	• Reduce infant deaths related to unsafe sleep • Increase access to OB care in underserved areas • Improve system of care for mothers with Substance Use Disorder

Strategy #1: Community education on Safe Sleep practices	
Target Population(s)	New parents in Bartholomew, Jennings and Jackson Counties
Partnering Organization(s)	Internal: OB offices, Birthing Center External: WIC, Family Service, Clarity, Su Casa
Results/Impact	• 1,023 safe sleep education modules completed by new parents • 0 unsafe sleep deaths in 2020 and 2022 • 24 months without an unsafe sleep death in Bartholomew County

Strategy #2: Pilot Nurse Navigator Program at OB Office (Southern IN OB)	
Target Population(s)	Women delivering at CRH, receiving care at SIOB
Partnering Organization(s)	Internal: Southern IN OB External: Indiana Department of Health
Results/Impact	• Nurse is carrying a caseload of 60 patients • Increased focus on Social Drivers of Health resource support • Increased provider and patient satisfaction • Hospital support to sustain role beyond grant funding • Pilot has led to additional funding to expand this program

Strategy #3: Initiate Fetal Infant Mortality Review, and develop Community Action Team in Jennings County	
Target Population(s)	Women of childbearing age in Jennings county
Partnering Organization(s)	Internal: Southern IN OB External: Nurse-Family Partnership, Jennings County Dept. of Health, Jennings County Family Court
Results/Impact	• Community Health Worker is providing Maternal infant health education, and has formed a Community Action Team • 1 fetal death and 1 infant death have been reviewed to date

Strategy #4: Improve access to prenatal care for residents of Jennings County	
Target Population(s)	Families of young children, women of childbearing age in Jennings county
Partnering Organization(s)	Internal: Southern IN OB External:
Results/Impact	• Ultrasound machine and fetal monitoring equipment available at satellite OB office, reducing barriers to receiving this important testing

Strategy #5: Provide bilingual Doula Care and Community Health Worker support for Spanish-speaking women	
Target Population(s)	Families whose native language is Spanish; recent Latin American immigrants
Partnering Organization(s)	Internal: OB offices External: Su Casa
Results/Impact	• 67 births supported by a bilingual Doula 2021-2023 • High staff and patient satisfaction

Strategy #6: Initiate evidence-based model of care for infants experiencing NAS	
Target Population(s)	Infants born to mothers who are using substances or are on Medication assisted treatment
Partnering Organization(s)	Internal: OB offices, Birthing Center, Peds Unit External: Nascend LLC
Results/Impact	• All Birthing Center staff received stigma reduction training • OB providers and nurses received training in Nascend model of care • App with scoring algorithm to guide care initiated in nursery • 58 mothers received a prenatal visit from Pediatric Hospitalist to receive anticipatory guidance on care of newborn experiencing NAS